

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: 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: 07/01/2020	To: 06/30/2021	

Type of Control

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

Type of Hospital

☒ XXXX XXXX General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

☒ XXXX XXXX Medicaid Hospital	☐ Medicaid Sub II Rehab	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable
By Fine And / Or Imprisonment Under Federal Law**

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Rush Copley Memorial Hospit 1007 for the cost report beginning 07/01/2020 and ending 06/30/2021 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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	157	57,305		39,306	68.59%		11,592	4.18
2.	Psych								
3.	Rehab	18	6,570		5,037	76.67%		371	13.58
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,030		5,744	71.53%			
6.	Coronary Care Unit								
7.	NICU	13	4,745		3,424	72.16%			
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		4,304	47.04%			
22.	Total	235	85,800		57,815	67.38%		11,963	4.47
23.	Observation Bed Days				7,677				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				787			163	9.88
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				433				
6.	Coronary Care Unit								
7.	NICU				391				
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				788				
22.	Total				2,399	4.15%		163	9.88

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:		Medicaid Provider Number:	
14-0029		1007	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2020	To: 06/30/2021

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)		(4)	(5)	(6)	(7)
1.	Operating Room	18,860,885	171,746,503	0.109818	1,826,490		200,581	
2.	Recovery Room	1,979,029	21,834,396	0.090638	99,672		9,034	
3.	Delivery and Labor Room	11,021,779	32,297,910	0.341254	751,630		256,497	
4.	Anesthesiology	873,055	32,897,341	0.026539	256,506		6,807	
5.	Radiology - Diagnostic	12,571,075	214,021,804	0.058737	1,467,855		86,217	
6.	Radiology - Therapeutic	14,228,633	33,306,575	0.427202				
7.	Nuclear Medicine							
8.	Laboratory	15,486,026	166,636,519	0.092933	2,824,110		262,453	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,337,345	37,575,392	0.195270	1,915,007		373,943	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	11,350,046	58,560,431	0.193818	493,569		95,663	
17.	EEG							
18.	Med. / Surg. Supplies	16,966,217	44,460,626	0.381601				
19.	Drugs Charged to Patients	29,388,461	251,755,960	0.116734	4,226,322		493,355	
20.	Renal Dialysis	1,478,344	7,209,409	0.205058	109,655		22,486	
21.	Ambulance							
22.	Same Day Surgery	4,818,751	18,364,388	0.262396	8,721		2,288	
23.	G.I. Lab	9,069,798	24,969,626	0.363233	107,383		39,005	
24.	Cardiac Rehab	2,443,557	2,787,393	0.876646				
25.	Rehab Services	7,692,262	50,253,312	0.153070	306,704		46,947	
26.	Implantable Devices	14,398,251	40,835,697	0.352590				
27.	Pancreas Acquisition							
28.	Wound Care Center	1,240,693	7,691,495	0.161307				
29.	MCAI	5,302,865	31,109,267	0.170459				
30.	Vascular Services	5,759,875	49,778,887	0.115709	520,511		60,228	
31.	Diabetic Center	415,956	353,745	1.175864				
32.	Yorkville	7,563,483	60,085,666	0.125878	105,335		13,259	
33.	Endocrinology	1,684,502	1,968,539	0.855712				
34.	MRI	1,451,384	24,524,196	0.059182	137,277		8,124	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	4,050,072	17,318,574	0.233857	19,968		4,670	
44.	Emergency	15,154,771	133,034,188	0.113916	944,699		107,616	
45.	Observation	9,441,098	14,724,340	0.641190				
46.	Total				16,121,414		2,089,173	

* 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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	57,767,376		3,831,550	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	46,983		5,037	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,229.54		760.68	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	787			
3.	Program general inpatient routine cost (Line 1c X Line 2)	967,648			
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)	967,648			

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	9,257,228	5,744	1,611.63	433	697,836
9.	Coronary Care Unit					
10.	NICU	8,943,084	3,424	2,611.88	391	1,021,245
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		4,304		788	
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,089,173
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,775,902

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: 07/01/2020 To: 06/30/2021

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)	
		(1)	(2)	(3)	(4)	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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	295,650	171,746,503	0.001721	1,826,490		3,143	
2.	Recovery Room							
3.	Delivery and Labor Room	785,490	32,297,910	0.024320	751,630		18,280	
4.	Anesthesiology	418,587	32,897,341	0.012724	256,506		3,264	
5.	Radiology - Diagnostic	95,250	214,021,804	0.000445	1,467,855		653	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	70,000	166,636,519	0.000420	2,824,110		1,186	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,229	37,575,392	0.000059	1,915,007		113	
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	1,154,040	2,787,393	0.414021				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center	18,000	7,691,495	0.002340				
29.	MCAI	894	31,109,267	0.000029				
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville	196,100	60,085,666	0.003264	105,335		344	
33.	Endocrinology							
34.	MRI							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	425,400	17,318,574	0.024563	19,968		490	
44.	Emergency	808,568	133,034,188	0.006078	944,699		5,742	
45.	Observation							
46.	Ancillary Total						33,215	

* 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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	246,850	46,983	5.25	787		4,132	
48.	Psych							
49.	Rehab	123,062	5,037	24.43				
50.	Other (Sub)							
51.	Intensive Care Unit	893,403	5,744	155.54	433		67,349	
52.	Coronary Care Unit							
53.	NICU	498,974	3,424	145.73	391		56,980	
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)						128,461	
68.	Ancillary Total (from line 46)						33,215	
69.	Total (Lines 67-68)						161,676	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0029		Medicaid Provider Number: 1007	
Program: Medicaid Hospital		Period Covered by Statement: From: 07/01/2020 To: 06/30/2021	
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)	4,775,902	
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)	161,676	
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)	30,400	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	4,967,978	
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)	16,121,414	
10.	Inpatient Routine Services (Provider's Records)		
A.	Adults and Pediatrics	2,882,170	
B.	Psych		
C.	Rehab		
D.	Other (Sub)		
E.	Intensive Care Unit	1,046,226	
F.	Coronary Care Unit		
G.	NICU	3,989,114	
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)	24,038,924	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		19,070,946
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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	4,967,978	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,967,978	
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)	4,967,978	

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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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)	19,070,946
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)	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: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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

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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	41,156	171,746,503	0.000240	1,826,490		438	
2.	Recovery Room							
3.	Delivery and Labor Room	92,601	32,297,910	0.002867	751,630		2,155	
4.	Anesthesiology							
5.	Radiology - Diagnostic	30,867	214,021,804	0.000144	1,467,855		211	
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	30,867	7,209,409	0.004281	109,655		469	
21.	Ambulance							
22.	Same Day Surgery							
23.	G.I. Lab							
24.	Cardiac Rehab	92,601	2,787,393	0.033221				
25.	Rehab Services							
26.	Implantable Devices							
27.	Pancreas Acquisition							
28.	Wound Care Center							
29.	MCAI							
30.	Vascular Services							
31.	Diabetic Center							
32.	Yorkville							
33.	Endocrinology							
34.	MRI							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	82,311	133,034,188	0.000619	944,699		585	
45.	Observation							
46.	Ancillary Total						3,858	

* 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:	14-0029	Medicaid Provider Number:	1007
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

Line No.	Cost Centers	G M E Cost (CMS 2552-10 W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10 W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	1,399,302	46,983	29.78	787		23,437	
48.	Psych							
49.	Rehab	123,468	5,037	24.51				
50.	Other (Sub)							
51.	Intensive Care Unit	41,156	5,744	7.17	433		3,105	
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.	Routine Total (lines 47-66)						26,542	
68.	Ancillary Total (from line 46)						3,858	
69.	Total (Lines 67-68)						30,400	

Preliminary

Medicare Provider Number: 14-0029	Medicaid Provider Number: 1007
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	1,611		1,611
Newborn Days	788		788
Total Inpatient Revenue	24,038,924		24,038,924
Ancillary Revenue	16,121,414		16,121,414
Routine Revenue	7,917,510		7,917,510
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - facility reports Nursery Days but did not reflect costs or charges on Worksheet C columns 1 & 8 of Medicare report. Also, didn't report any Nursery Customary Charges on BHF page 7.

BHF Page 2 - Added the Rehab beds and bed days to the Part I-Hospital

BHF Page 2 - Adjusted the Program discharges as the hospital reported the total XIX discharges from the Medicare report W/S S-3; however the Program days are less than those on XIX of the Medicare report; adjusted as follows:

$$1611 \text{ (A\&P + ICU + CCU days)} / 6122 \text{ total A\&P, ICU \& CCU XIX Medicare days} * 621 \text{ total discharges} = 163$$

BHF Page 2 - I/P Program days agree with the IPCR (nursery off by 1)

BHF Page 4 - Agreed Line 1, A&P to W/S C as less than W/S D-1