

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: University of Illinois Medical Center at Chicago		Medicare Provider Number: 14-0150
Street: 1740 W. Taylor Street		Medicaid Provider Number: 3098
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 07/01/2007	To: 06/30/2008

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

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

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I	<input type="checkbox"/> Medicaid Sub III	<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)) University of Illinois Medical C 3098 for the cost report beginning 07/01/2007 and ending 06/30/2008 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 _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Sections 5-5 and 5-7 of the Healthcare and Family Services Code (Ill. Rev. Stat. Ch. 23, Par. 5/5, 5/7. 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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

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	284	104,061		74,134	71.24%		21,027	5.04
2.	Psych	46	16,836		14,106	83.78%		1,158	12.18
3.	Rehab	17	6,222		4,038	64.90%		356	11.34
4.	Sub III								
5.	Intensive Care Unit	22	8,052		6,522	81.00%			
6.	Coronary Care Unit	19	6,954		5,517	79.34%			
7.	Pediatric ICU	21	7,686		4,407	57.34%			
8.	Neonatal ICU	62	22,692		15,337	67.59%			
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	9,125		4,768	52.25%			
22.	Total	496	181,628		128,829	70.93%		22,541	5.50
23.	Observation Bed Days				2,570				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				27,143			8,975	4.95
2.	Psych								
3.	Rehab								
4.	Sub III								
5.	Intensive Care Unit				1,647				
6.	Coronary Care Unit				1,548				
7.	Pediatric ICU				2,903				
8.	Neonatal ICU				11,168				
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				3,176				
22.	Total				47,585	36.94%		8,975	4.95

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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552, 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	44,558,910	141,060,436	0.315885	23,796,939	17,225,142	7,517,096	5,441,164
2.	Recovery Room	2,283,326	8,113,702	0.281416	871,265	1,737,363	245,188	488,922
3.	Delivery and Labor Room	10,287,438	21,278,036	0.483477	12,130,017	2,588,303	5,864,584	1,251,385
4.	Anesthesiology	2,890,209	39,190,368	0.073748	9,365,070	4,973,428	690,655	366,780
5.	Radiology - Diagnostic	19,910,318	160,586,188	0.123985	22,069,349	17,247,587	2,736,268	2,138,442
6.	Radiology - Therapeutic	6,088,585	14,797,354	0.411464	174,712	3,579,900	71,888	1,473,000
7.	Nuclear Medicine	2,042,047	6,563,256	0.311133	593,266	922,095	184,585	286,894
8.	Laboratory	41,904,735	265,808,724	0.157650	29,468,902	21,856,384	4,645,772	3,445,659
9.	Blood							
10.	Blood - Administration	11,033,320	31,282,007	0.352705	7,505,439	2,233,921	2,647,206	787,915
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,398,538	40,487,559	0.108639	17,051,770	697,350	1,852,487	75,759
13.	Physical Therapy	4,362,055	7,746,352	0.563111	827,553	1,422,083	466,004	800,791
14.	Occupational Therapy	2,345,376	3,967,825	0.591099	390,029	312,624	230,546	184,792
15.	Speech Pathology	1,301,032	2,872,801	0.452879	228,576	1,020,931	103,517	462,358
16.	EKG	439,177	2,707,474	0.162209	504,520	234,880	81,838	38,100
17.	EEG	1,044,636	4,759,104	0.219503	991,233	328,205	217,579	72,042
18.	Med. / Surg. Supplies	26,999,770	37,234,610	0.725126	12,446,127	247,841	9,025,010	179,716
19.	Drugs Charged to Patients	49,922,313	169,367,612	0.294757	54,318,289	4,108,741	16,010,696	1,211,080
20.	Renal Dialysis	7,783,003	29,027,153	0.268128	1,971,252	3,554,526	528,548	953,068
21.	Ambulance							
22.	Heart Cath Lab	5,399,788	35,571,601	0.151801	6,555,651	3,079,547	995,154	467,478
23.	Prosthetics	1,954,091	1,416,693	1.379333	4,219	282,088	5,819	389,093
24.	Other Transplant	1,168,549	1,086,655	1.075363	283,101	30,593	304,436	32,899
25.	Eye Clinic	8,840,667	9,978,685	0.885955	4,243	2,244,067	3,759	1,988,142
26.	Primary Care Clinic	4,855,851	8,791,443	0.552338	88,598	4,914,124	48,936	2,714,257
27.	Child & Adol Clinic	4,711,693	10,746,475	0.438441	23,701	7,563,618	10,391	3,316,200
28.	Neuropsych Clinic	6,954,500	6,352,346	1.094792		2,432,354		2,662,922
29.	Kidney Acquisition	4,883,755	4,883,755	1.000000	1,372,460	71,970	1,372,460	71,970
30.	Liver Acquisition	1,890,809	1,890,809	1.000000	1,328,334		1,328,334	
31.	Pancreas Acquisition	634,929	634,929	1.000000	252,198		252,198	
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	46,450,376	61,990,194	0.749318	1,621,983	11,017,387	1,215,381	8,255,526
44.	Emergency	12,763,170	48,450,175	0.263429	5,889,123	12,567,548	1,551,366	3,310,657
45.	Observation	2,753,267	4,525,224	0.608427	111,089	1,364,323	67,590	830,091
46.	Total				212,239,008	129,858,923	60,275,291	43,697,102

* 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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	82,174,093	11,668,877	3,400,424	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	76,704	14,106	4,038	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,071.31	827.23	842.11	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	27,143			
3.	Program general inpatient routine cost (Line 1c X Line 2)	29,078,567			
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)	29,078,567			

Line No.	Description	Total Dept. Costs (CMS 2552, W/S C Part 1, Col. 1)	Total Days (CMS 2552, W/S S-3, Part 1, Col. 6)	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	13,158,085	6,522	2,017.49	1,647	3,322,806
9.	Coronary Care Unit	12,456,401	5,517	2,257.82	1,548	3,495,105
10.	Pediatric ICU	8,495,958	4,407	1,927.83	2,903	5,596,490
11.	Neonatal ICU	20,668,657	15,337	1,347.63	11,168	15,050,332
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,434,959	4,768	510.69	3,176	1,621,951
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					60,275,291
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					118,440,542

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

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Pediatric ICU						
9.	Neonatal 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, W/S D-2, Col. 1)	Expense Allocation (CMS 2552, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552, W/S C, Pt. 1, Lines 60-63)	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)
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552, 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							
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.	Heart Cath Lab							
23.	Prosthetics							
24.	Other Transplant							
25.	Eye Clinic							
26.	Primary Care Clinic							
27.	Child & Adol Clinic							
28.	Neuropsych Clinic							
29.	Kidney Acquisition							
30.	Liver Acquisition							
31.	Pancreas Acquisition							
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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	Professional Component (CMS 2552, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552, W/S S-3 Pt. 1, Col. 6)	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							
48.	Psych							
49.	Rehab							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Pediatric ICU							
54.	Neonatal 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)							

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		43,697,102
2.	Inpatient Operating Services (BHF Page 4, Line 25)	118,440,542	
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)	9,990,241	3,999,662
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	128,430,783	47,696,764
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	73.00%	27.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	212,239,008	129,858,923
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	28,269,202	
	B. Psych		
	C. Rehab		
	D. Sub III		
	E. Intensive Care Unit	3,325,300	
	F. Coronary Care Unit	3,292,826	
	G. Pediatric ICU	5,467,143	
	H. Neonatal ICU	20,434,980	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,328,950	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	275,357,409	129,858,923
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		229,088,785
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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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)	128,430,783	47,696,764
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	128,430,783	47,696,764
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, Sec. 115.2 (B)		
6.	Total Allowable Cost (Sum of Lines 3 and 4, Plus or Minus Line 5)	128,430,783	47,696,764

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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 Health Insurance Regulation Section 405, 460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	229,088,785
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			1.	Cost Report Period ended		
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

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

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2007 To: 06/30/2008

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, Supplemental W/S D-9, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552, Supplemental W/S D-9, 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 Sub III
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 Sub III
7. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
8. 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 Sub III
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552, 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, 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 1)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Dept. Charges (CMS 2552, 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	5,309,962	141,060,436	0.037643	23,796,939	17,225,142	895,788	648,406
2.	Recovery Room	75,100	8,113,702	0.009256	871,265	1,737,363	8,064	16,081
3.	Delivery and Labor Room	754,618	21,278,036	0.035465	12,130,017	2,588,303	430,191	91,794
4.	Anesthesiology	1,247,095	39,190,368	0.031821	9,365,070	4,973,428	298,006	158,259
5.	Radiology - Diagnostic	3,895,154	160,586,188	0.024256	22,069,349	17,247,587	535,314	418,357
6.	Radiology - Therapeutic	950,194	14,797,354	0.064214	174,712	3,579,900	11,219	229,880
7.	Nuclear Medicine	184,434	6,563,256	0.028101	593,266	922,095	16,671	25,912
8.	Laboratory	6,167,796	265,808,724	0.023204	29,468,902	21,856,384	683,796	507,156
9.	Blood							
10.	Blood - Administration	1,037,841	31,282,007	0.033177	7,505,439	2,233,921	249,008	74,115
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,184,891	40,487,559	0.029266	17,051,770	697,350	499,037	20,409
13.	Physical Therapy	241,767	7,746,352	0.031210	827,553	1,422,083	25,828	44,383
14.	Occupational Therapy	126,398	3,967,825	0.031856	390,029	312,624	12,425	9,959
15.	Speech Pathology	113,171	2,872,801	0.039394	228,576	1,020,931	9,005	40,219
16.	EKG	278,615	2,707,474	0.102906	504,520	234,880	51,918	24,171
17.	EEG	44,050	4,759,104	0.009256	991,233	328,205	9,175	3,038
18.	Med. / Surg. Supplies	1,378,198	37,234,610	0.037014	12,446,127	247,841	460,681	9,174
19.	Drugs Charged to Patients	6,468,690	169,367,612	0.038193	54,318,289	4,108,741	2,074,578	156,925
20.	Renal Dialysis	1,596,018	29,027,153	0.054984	1,971,252	3,554,526	108,387	195,442
21.	Ambulance							
22.	Heart Cath Lab	1,454,786	35,571,601	0.040897	6,555,651	3,079,547	268,106	125,944
23.	Prosthetics	13,113	1,416,693	0.009256	4,219	282,088	39	2,611
24.	Other Transplant	10,058	1,086,655	0.009256	283,101	30,593	2,620	283
25.	Eye Clinic	271,706	9,978,685	0.027229	4,243	2,244,067	116	61,104
26.	Primary Care Clinic	282,362	8,791,443	0.032118	88,598	4,914,124	2,846	157,832
27.	Child & Adol Clinic	417,958	10,746,475	0.038893	23,701	7,563,618	922	294,172
28.	Neuropsych Clinic	290,707	6,352,346	0.045764		2,432,354		111,314
29.	Kidney Acquisition	230,989	4,883,755	0.047297	1,372,460	71,970	64,913	3,404
30.	Liver Acquisition	163,133	1,890,809	0.086277	1,328,334		114,605	
31.	Pancreas Acquisition	7,781	634,929	0.012255	252,198		3,091	
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	1,235,497	61,990,194	0.019931	1,621,983	11,017,387	32,328	219,588
44.	Emergency	1,348,265	48,450,175	0.027828	5,889,123	12,567,548	163,883	349,730
45.	Observation							
46.	Ancillary Total						7,032,560	3,999,662

* 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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2007 To: 06/30/2008

Line No.	Cost Centers	G M E Cost (CMS 2552, W/S B, Pt. 1, Col. 26)	Total Days Including Private (W/S S-3, Part 1, Col. 6)	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	3,958,084	76,704	51.60	27,143		1,400,579	
48.	Psych	563,909	14,106	39.98				
49.	Rehab							
50.	Sub Ill							
51.	Intensive Care Unit	646,981	6,522	99.20	1,647		163,382	
52.	Coronary Care Unit	565,465	5,517	102.50	1,548		158,670	
53.	Pediatric ICU	385,749	4,407	87.53	2,903		254,100	
54.	Neonatal ICU	1,249,032	15,337	81.44	11,168		909,522	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	107,220	4,768	22.49	3,176		71,428	
67.	Routine Total (lines 47-66)						2,957,681	
68.	Ancillary Total (from line 46)						7,032,560	3,999,662
69.	Total (Lines 67-68)						9,990,241	3,999,662

