

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: 07/01/2008	To: 06/30/2009	

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 type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input checked="" type="checkbox"/> Medicaid Sub I Psych	<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 07/01/2008 and ending 06/30/2009 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-Psych	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	294	107,395		72,812	67.80%		20,502	5.11
2.	Psych	46	16,934		13,705	80.93%		1,131	12.12
3.	Rehab	17	6,205		4,171	67.22%		367	11.37
4.	Sub III								
5.	Intensive Care Unit	22	8,030		6,655	82.88%			
6.	Coronary Care Unit	19	6,916		5,223	75.52%			
7.	Pediatric ICU	21	7,665		4,461	58.20%			
8.	Neonatal ICU	65	23,551		15,565	66.09%			
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		4,784	52.43%			
22.	Total	509	185,821		127,376	68.55%		22,000	5.57
23.	Observation Bed Days				3,622				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				7,889			213	37.04
3.	Rehab								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU								
8.	Neonatal 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				7,889	6.19%		213	37.04

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-Psych	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	44,914,252	144,813,078	0.310153	71,450		22,160	
2.	Recovery Room	2,247,449	7,022,107	0.320053	65,006		20,805	
3.	Delivery and Labor Room	10,806,332	24,825,896	0.435285	16,777		7,303	
4.	Anesthesiology	3,620,869	39,456,563	0.091768	84,290		7,735	
5.	Radiology - Diagnostic	26,535,455	182,716,774	0.145227	251,008		36,453	
6.	Radiology - Therapeutic	6,858,865	16,438,023	0.417256	23,448		9,784	
7.	Nuclear Medicine	2,775,932	7,344,905	0.377940	10,935		4,133	
8.	Laboratory	47,027,722	296,002,557	0.158876	751,819		119,446	
9.	Blood							
10.	Blood - Administration	8,097,390	26,118,207	0.310029	35,626		11,045	
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,137,050	48,165,044	0.106655	55,351		5,903	
13.	Physical Therapy	4,423,490	9,336,467	0.473786	9,465		4,484	
14.	Occupational Therapy	2,267,484	3,962,819	0.572190	557,881		319,214	
15.	Speech Pathology	1,358,190	2,244,383	0.605151	3,357		2,031	
16.	EKG	409,218	3,259,311	0.125554	25,183		3,162	
17.	EEG	1,365,731	5,358,798	0.254858	44,593		11,365	
18.	Med. / Surg. Supplies	27,804,809	39,421,949	0.705313	265,699		187,401	
19.	Drugs Charged to Patients	51,486,408	163,632,741	0.314646	1,506,073		473,880	
20.	Renal Dialysis	8,147,166	32,602,164	0.249896				
21.	Ambulance							
22.	Heart Cath Lab	9,350,504	40,971,563	0.228219	32,699		7,463	
23.	Prosthetics	1,930,976	1,273,241	1.516583				
24.	Other Transplant	1,164,601	498,480	2.336304				
25.	Eye Clinic	6,835,732	8,489,363	0.805211				
26.	Primary Care Clinic	5,108,940	8,945,064	0.571146				
27.	Child & Adol Clinic	4,500,730	9,117,465	0.493638				
28.	Neuropsych Clinic	6,423,733	6,383,940	1.006233	3,035		3,054	
29.	Kidney Acquisition	6,465,597	6,162,568	1.049173				
30.	Liver Acquisition	2,831,236	2,611,887	1.083981				
31.	Pancreas Acquisition	763,456	752,317	1.014806				
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	44,281,512	91,900,283	0.481843	2,522		1,215	
44.	Emergency	13,161,003	53,578,068	0.245642	477,796		117,367	
45.	Observation	4,026,976	6,137,800	0.656094	1,251		821	
46.	Total				4,295,264		1,376,224	

* 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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	84,980,069	11,600,859	3,348,106	
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	76,434	13,705	4,171	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,111.81	846.47	802.71	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		7,889		
3.	Program general inpatient routine cost (Line 1c X Line 2)		6,677,802		
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)		6,677,802		

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	12,956,897	6,655	1,946.94		
9.	Coronary Care Unit	11,639,237	5,223	2,228.46		
10.	Pediatric ICU	8,502,220	4,461	1,905.90		
11.	Neonatal ICU	21,607,126	15,565	1,388.19		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,358,389	4,784	492.97		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,376,224
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					8,054,026

**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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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-Psych	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	8,054,026	
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)	591,491	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	8,645,517	
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)	4,295,264	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	10,113,712	
	C. Rehab		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Pediatric ICU		
	H. Neonatal 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)	14,408,976	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,763,459
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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	8,645,517	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	8,645,517	
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)	8,645,517	

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-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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)	5,763,459
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)
			(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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

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-Psych	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	6,868,339	144,813,078	0.047429	71,450		3,389	
2.	Recovery Room	80,558	7,022,107	0.011472	65,006		746	
3.	Delivery and Labor Room	1,000,520	24,825,896	0.040301	16,777		676	
4.	Anesthesiology	1,602,618	39,456,563	0.040617	84,290		3,424	
5.	Radiology - Diagnostic	5,228,396	182,716,774	0.028615	251,008		7,183	
6.	Radiology - Therapeutic	1,246,069	16,438,023	0.075804	23,448		1,777	
7.	Nuclear Medicine	245,096	7,344,905	0.033370	10,935		365	
8.	Laboratory	8,216,785	296,002,557	0.027759	751,819		20,870	
9.	Blood							
10.	Blood - Administration	1,272,682	26,118,207	0.048728	35,626		1,736	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,606,020	48,165,044	0.033344	55,351		1,846	
13.	Physical Therapy	328,257	9,336,467	0.035159	9,465		333	
14.	Occupational Therapy	162,067	3,962,819	0.040897	557,881		22,816	
15.	Speech Pathology	138,333	2,244,383	0.061635	3,357		207	
16.	EKG	367,103	3,259,311	0.112632	25,183		2,836	
17.	EEG	61,476	5,358,798	0.011472	44,593		512	
18.	Med. / Surg. Supplies	1,847,495	39,421,949	0.046865	265,699		12,452	
19.	Drugs Charged to Patients	8,250,293	163,632,741	0.050420	1,506,073		75,936	
20.	Renal Dialysis	1,758,716	32,602,164	0.053945				
21.	Ambulance							
22.	Heart Cath Lab	1,933,626	40,971,563	0.047194	32,699		1,543	
23.	Prosthetics	14,607	1,273,241	0.011472				
24.	Other Transplant	5,472	498,480	0.010977				
25.	Eye Clinic	330,601	8,489,363	0.038943				
26.	Primary Care Clinic	363,975	8,945,064	0.040690				
27.	Child & Adol Clinic	518,747	9,117,465	0.056896				
28.	Neuropsych Clinic	374,803	6,383,940	0.058710	3,035		178	
29.	Kidney Acquisition	303,029	6,162,568	0.049173				
30.	Liver Acquisition	219,349	2,611,887	0.083981				
31.	Pancreas Acquisition	11,139	752,317	0.014806				
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	1,914,749	91,900,283	0.020835	2,522		53	
44.	Emergency	1,784,725	53,578,068	0.033311	477,796		15,916	
45.	Observation							
46.	Ancillary Total						174,794	

* 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-Psych	Period Covered by Statement:	From: 07/01/2008 To: 06/30/2009

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	5,117,198	76,434	66.95				
48.	Psych	723,894	13,705	52.82	7,889		416,697	
49.	Rehab	61,241	4,171	14.68				
50.	Sub III							
51.	Intensive Care Unit	837,177	6,655	125.80				
52.	Coronary Care Unit	720,848	5,223	138.01				
53.	Pediatric ICU	502,045	4,461	112.54				
54.	Neonatal ICU	1,636,453	15,565	105.14				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	139,352	4,784	29.13				
67.	Routine Total (lines 47-66)						416,697	
68.	Ancillary Total (from line 46)						174,794	
69.	Total (Lines 67-68)						591,491	

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Psych	Period Covered by Statement: From: 07/01/2008 To: 06/30/2009

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,889		7,889
Newborn Days			
Total Inpatient Revenue	14,408,976		14,408,976
Ancillary Revenue	4,295,264		4,295,264
Routine Revenue	10,113,712		10,113,712
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- Observation Days were taken from filed S-3.
- Reclassified Blood charges as Blood Admin.
- Radiology-Diagnostic Includes 41.03 CT Scan, 41.04 MRI, 41.05 Ultrasound, and 41.06 Vascular Xray.
- Reclassified Oncology as Radiology-Therapeutic to match filed Cost Report.
- Laboratory Includes 44.01 Histocompatibility Lab and 44.02 Outreach Lab.
- Respiratory Therapy Includes 58.06 Pulmonary Lab.
- Heart Cath Lab Includes 58.02 Cardiovascular Svcs.
- Clinic Includes 58.04 Gastro Services.
- BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
- BHF Page 3 Charges match filed W/S C, Pt 1, Col 8 except Other Organ Transplant.
- Other Organ Transplant Charges are greater than filed W/S C.
- Organ Acquisition Costs are from filed W/S B, Pt 1, Col 25.
- Organ Acquisition Charges are from filed W/S D-6, Line 51.
- GME Costs were adjusted to filed W/S B, Pt 1, Col 26.