

Hospital Statement of Cost

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

General Information PRELIMINARY-Revised 09/02/2011

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 checked="" type="checkbox"/> State
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County
		<input type="checkbox"/> Township
		<input type="checkbox"/> Hospital District
		<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 checked="" type="checkbox"/> Medicaid Sub II Rehabilitation	<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 07/01/2008 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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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								
3.	Rehab				1,753			133	13.18
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				1,753	1.38%		133	13.18

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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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	44,818,570	144,813,078	0.309493	49,037		15,177	
2.	Recovery Room	2,242,661	7,022,107	0.319372	1,632		521	
3.	Delivery and Labor Room	10,783,305	24,825,896	0.434357	23		10	
4.	Anesthesiology	3,613,176	39,456,563	0.091574	12,632		1,157	
5.	Radiology - Diagnostic	26,457,853	182,716,774	0.144803	102,551		14,850	
6.	Radiology - Therapeutic	6,844,250	16,438,023	0.416367	17,383		7,238	
7.	Nuclear Medicine	2,770,018	7,344,905	0.377135	2,898		1,093	
8.	Laboratory	46,926,615	296,002,557	0.158534	194,265		30,798	
9.	Blood							
10.	Blood - Administration	8,080,138	26,118,207	0.309368	36,519		11,298	
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,126,129	48,165,044	0.106428	157,388		16,750	
13.	Physical Therapy	4,414,064	9,336,467	0.472777	435,503		205,896	
14.	Occupational Therapy	2,262,651	3,962,819	0.570970	485,408		277,153	
15.	Speech Pathology	1,355,295	2,244,383	0.603861	171,670		103,665	
16.	EKG	408,347	3,259,311	0.125286	4,531		568	
17.	EEG	1,362,824	5,358,798	0.254315	4,987		1,268	
18.	Med. / Surg. Supplies	27,745,540	39,421,949	0.703809	115,940		81,600	
19.	Drugs Charged to Patients	51,376,719	163,632,741	0.313976	581,996		182,733	
20.	Renal Dialysis	8,128,310	32,602,164	0.249318	96,536		24,068	
21.	Ambulance							
22.	Heart Cath Lab	9,320,592	40,971,563	0.227489	13,753		3,129	
23.	Prosthetics	1,914,329	1,273,241	1.503509				
24.	Other Transplant	1,531,459	498,480	3.072258				
25.	Eye Clinic	6,767,672	8,489,363	0.797194				
26.	Primary Care Clinic	5,055,961	8,945,064	0.565224				
27.	Child & Adol Clinic	4,460,015	9,117,465	0.489173				
28.	Neuropsych Clinic	6,367,889	6,383,940	0.997486				
29.	Kidney Acquisition	6,455,671	6,162,568	1.047562				
30.	Liver Acquisition	2,610,755	2,611,887	0.999567				
31.	Pancreas Acquisition	750,714	752,317	0.997869				
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	43,788,736	91,900,283	0.476481	11,151		5,313	
44.	Emergency	13,132,974	53,578,068	0.245118	1,813		444	
45.	Observation	4,006,222	6,137,800	0.652713				
46.	Total				2,497,616		984,729	

* 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-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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)	84,541,807	11,576,135	3,340,968	
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)	1,106.08	844.67	801.00	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,753	
3.	Program general inpatient routine cost (Line 1c X Line 2)			1,404,153	
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)			1,404,153	

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	12,929,282	6,655	1,942.79		
9.	Coronary Care Unit	11,614,428	5,223	2,223.71		
10.	Pediatric ICU	8,484,099	4,461	1,901.84		
11.	Neonatal ICU	21,561,082	15,565	1,385.23		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,353,363	4,784	491.92		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					984,729
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,388,882

**Hospital Statement of Cost
Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**
PRELIMINARY-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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)
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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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)	2,388,882	
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)	132,326	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,521,208	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	2,497,616	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	1,987,508	
	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)	4,485,124	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,963,916
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-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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)	2,521,208	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,521,208	
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)	2,521,208	

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-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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)	1,963,916
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-Revised 09/02/2011

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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	6,853,760	144,813,078	0.047328	49,037		2,321	
2.	Recovery Room	80,389	7,022,107	0.011448	1,632		19	
3.	Delivery and Labor Room	998,398	24,825,896	0.040216	23		1	
4.	Anesthesiology	1,599,219	39,456,563	0.040531	12,632		512	
5.	Radiology - Diagnostic	5,217,330	182,716,774	0.028554	102,551		2,928	
6.	Radiology - Therapeutic	1,243,419	16,438,023	0.075643	17,383		1,315	
7.	Nuclear Medicine	244,576	7,344,905	0.033299	2,898		97	
8.	Laboratory	8,198,701	296,002,557	0.027698	194,265		5,381	
9.	Blood							
10.	Blood - Administration	1,269,980	26,118,207	0.048624	36,519		1,776	
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,602,619	48,165,044	0.033273	157,388		5,237	
13.	Physical Therapy	327,561	9,336,467	0.035084	435,503		15,279	
14.	Occupational Therapy	161,723	3,962,819	0.040810	485,408		19,810	
15.	Speech Pathology	138,039	2,244,383	0.061504	171,670		10,558	
16.	EKG	366,322	3,259,311	0.112392	4,531		509	
17.	EEG	61,348	5,358,798	0.011448	4,987		57	
18.	Med. / Surg. Supplies	1,843,573	39,421,949	0.046765	115,940		5,422	
19.	Drugs Charged to Patients	8,232,778	163,632,741	0.050313	581,996		29,282	
20.	Renal Dialysis	1,756,485	32,602,164	0.053876	96,536		5,201	
21.	Ambulance							
22.	Heart Cath Lab	1,929,522	40,971,563	0.047094	13,753		648	
23.	Prosthetics	14,576	1,273,241	0.011448				
24.	Other Transplant	45,829	498,480	0.091937				
25.	Eye Clinic	329,900	8,489,363	0.038860				
26.	Primary Care Clinic	363,203	8,945,064	0.040604				
27.	Child & Adol Clinic	517,645	9,117,465	0.056775				
28.	Neuropsych Clinic	374,006	6,383,940	0.058585				
29.	Kidney Acquisition	302,388	6,162,568	0.049069				
30.	Liver Acquisition	218,883	2,611,887	0.083803				
31.	Pancreas Acquisition	11,116	752,317	0.014776				
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	1,910,708	91,900,283	0.020791	11,151		232	
44.	Emergency	1,780,944	53,578,068	0.033240	1,813		60	
45.	Observation							
46.	Ancillary Total						106,645	

* 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-Revised 09/02/2011

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	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	5,106,338	76,434	66.81				
48.	Psych	722,357	13,705	52.71				
49.	Rehab	61,113	4,171	14.65	1,753		25,681	
50.	Sub Ill							
51.	Intensive Care Unit	835,402	6,655	125.53				
52.	Coronary Care Unit	719,318	5,223	137.72				
53.	Pediatric ICU	500,981	4,461	112.30				
54.	Neonatal ICU	1,632,984	15,565	104.91				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	139,058	4,784	29.07				
67.	Routine Total (lines 47-66)						25,681	
68.	Ancillary Total (from line 46)						106,645	
69.	Total (Lines 67-68)						132,326	

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

PRELIMINARY-Revised 09/02/2011

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,753		1,753
Newborn Days			
Total Inpatient Revenue	4,485,124		4,485,124
Ancillary Revenue	2,497,616		2,497,616
Routine Revenue	1,987,508		1,987,508
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 27.
 - 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.
- Revision due to revision of Medicare report-12/21/2010----DW.