

Hospital Statement of Cost

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

General Information **REVISED-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: 07/01/2011	To: 06/30/2012

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"/> 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 Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<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 (3098 for the cost report beginning 07/01/2011 and ending 06/30/2012 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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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	302	109,882		72,052	65.57%		19,167	5.12
2.	Psych	45	16,470		13,783	83.69%		1,148	12.01
3.	Rehab	17	6,222		3,769	60.58%		320	11.78
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,052		6,621	82.23%			
6.	Coronary Care Unit	22	7,044		4,527	64.27%			
7.	Pediatric ICU	17	7,298		2,762	37.85%			
8.	Neonatal ICU	58	21,228		12,121	57.10%			
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				4,238				
22.	Total	483	176,196		119,873	68.03%		20,635	5.60
23.	Observation Bed Days				6,039				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				23,807			6,916	5.05
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,246				
6.	Coronary Care Unit				1,100				
7.	Pediatric ICU				1,963				
8.	Neonatal ICU				6,800				
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				2,595				
22.	Total				37,511	31.29%		6,916	5.05

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	135,162	505,568

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	37,618,261	97,123,532	0.387324	10,975,235	16,626,825	4,250,972	6,439,968
2.	Recovery Room	3,806,975	7,527,967	0.505711	701,096	1,701,774	354,552	860,606
3.	Delivery and Labor Room	14,226,333	27,433,951	0.518567	12,653,213	2,222,668	6,561,539	1,152,602
4.	Anesthesiology	3,453,730	42,893,851	0.080518	7,738,973	6,294,191	623,127	506,796
5.	Radiology - Diagnostic	6,341,565	25,363,749	0.250025	2,196,555	4,251,683	549,194	1,063,027
6.	Radiology - Therapeutic	10,141,646	30,143,874	0.336441	278,043	3,132,659	93,545	1,053,955
7.	Nuclear Medicine	1,631,864	5,457,462	0.299015	326,707	913,566	97,690	273,170
8.	Laboratory	37,200,495	236,413,809	0.157353	28,578,392	36,001,564	4,496,896	5,664,954
9.	Blood							
10.	Blood - Administration	7,825,390	27,241,251	0.287263	5,820,561	1,872,679	1,672,032	537,951
11.	Intravenous Therapy	1,177,941	504,960	2.332741		2,977		6,945
12.	Respiratory Therapy	5,581,496	25,650,065	0.217602	6,333,603	1,172,562	1,378,205	255,152
13.	Physical Therapy	6,418,208	13,919,181	0.461105	869,625	2,748,120	400,988	1,267,172
14.	Occupational Therapy	2,616,269	5,414,395	0.483206	345,127	478,912	166,767	231,413
15.	Speech Pathology	778,790	1,368,227	0.569196	299,651	287,261	170,560	163,508
16.	EKG	525,121	4,327,531	0.121344	590,300	475,705	71,629	57,724
17.	EEG	828,225	3,894,758	0.212651	738,392	174,998	157,020	37,213
18.	Med. / Surg. Supplies	64,113,306	189,883,568	0.337645	32,086,436	12,508,755	10,833,825	4,223,519
19.	Drugs Charged to Patients	65,724,799	228,597,888	0.287513	53,761,838	11,216,283	15,457,227	3,224,827
20.	Renal Dialysis	9,414,994	33,430,784	0.281626	1,783,954	3,518,507	502,408	990,903
21.	Ambulance							
22.	Ultrasound	2,061,954	9,865,402	0.209009	1,159,877	1,509,697	242,425	315,540
23.	Radiology Angiography	7,017,005	56,897,173	0.123328	5,884,655	3,519,439	725,743	434,045
24.	Radiology W. Harrison	2,052,888	10,520,129	0.195139	3,445	2,066,658	672	403,286
25.	CT Scan	4,430,279	49,452,001	0.089587	5,324,220	6,397,257	476,981	573,111
26.	MRI	3,220,758	32,855,150	0.098029	2,821,393	5,832,119	276,578	571,717
27.	Cardiac Catheterization	3,019,699	11,620,229	0.259866	1,172,213	1,392,714	304,618	361,919
28.	Lab Issue Typing	2,000,340	4,552,391	0.439404	204,195	408,611	89,724	179,545
29.	Lab Outreach	14,800,969	127,540,744	0.116049				
30.	Gastroenterology	4,219,428	21,247,603	0.198584	1,385,090	2,932,730	275,057	582,393
31.	Bone Marrow Transplant	1,238,698	539,564	2.295739	145,800	20,179	334,719	46,326
32.	Cardiac Services	4,829,064	20,921,588	0.230817	2,578,792	1,954,963	595,229	451,239
33.	Kidney Acquisition	6,850,030	11,221,593	0.610433	1,943,898		1,186,619	
34.	Liver Acquisition	2,604,375	4,124,564	0.631430	1,061,679		670,376	
35.	Pancreas Acquisition	1,152,979	1,983,440	0.581303	198,344		115,298	
36.	Islet Acquisition	222,392	78,401	2.836596				
37.	Other Organ Acquisition	210,275						
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	70,953,166	107,729,746	0.658622	129,533	34,454,745	85,313	22,692,653
44.	Emergency	16,068,742	63,583,041	0.252721	6,126,959	15,175,680	1,548,411	3,835,213
45.	Observation	8,449,708	14,209,732	0.594642	887,520	3,917,044	527,757	2,329,239
46.	Total				197,105,314	185,183,525	55,293,696	60,787,631

* 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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	109,264,087	16,038,278	4,429,763	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	78,091	13,783	3,769	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,399.19	1,163.63	1,175.32	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	23,807			
3.	Program general inpatient routine cost (Line 1c X Line 2)	33,310,516			
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)	33,310,516			

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	16,583,490	6,621	2,504.68	1,246	3,120,831
9.	Coronary Care Unit	13,606,456	4,527	3,005.62	1,100	3,306,182
10.	Pediatric ICU	8,101,507	2,762	2,933.20	1,963	5,757,872
11.	Neonatal ICU	22,504,293	12,121	1,856.64	6,800	12,625,152
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,274,623	4,238	772.68	2,595	2,005,105
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					55,293,696
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					115,419,354

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

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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.	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 2552-10, 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)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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							
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.	Ultrasound							
23.	Radiology Angiography							
24.	Radiology W. Harrison							
25.	CT Scan							
26.	MRI							
27.	Cardiac Catheterization							
28.	Lab Issue Typing							
29.	Lab Outreach							
30.	Gastroenterology							
31.	Bone Marrow Transplant							
32.	Cardiac Services							
33.	Kidney Acquisition							
34.	Liver Acquisition							
35.	Pancreas Acquisition							
36.	Islet Acquisition							
37.	Other Organ Acquisition							
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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
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**

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150		Medicaid Provider Number: 3098	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2011 To: 06/30/2012	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		60,787,631
2.	Inpatient Operating Services (BHF Page 4, Line 25)	115,419,354	
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)	10,905,097	6,763,388
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	126,324,451	67,551,019
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	65.00%	35.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	197,105,314	185,183,525
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	38,086,112	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,437,378	
	F. Coronary Care Unit	3,778,767	
	G. Pediatric ICU	5,820,895	
	H. Neonatal ICU	19,339,122	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,097,850	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	270,665,438	185,183,525
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		261,973,493
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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	126,324,451	67,551,019
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	126,324,451	67,551,019
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)	126,324,451	67,551,019

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.

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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)	261,973,493
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 (1)	to (2)	to (3)		
		(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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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	6,851,131	97,123,532	0.070540	10,975,235	16,626,825	774,193	1,172,856
2.	Recovery Room	89,846	7,527,967	0.011935	701,096	1,701,774	8,368	20,311
3.	Delivery and Labor Room	1,110,634	27,433,951	0.040484	12,653,213	2,222,668	512,253	89,982
4.	Anesthesiology	1,768,455	42,893,851	0.041229	7,738,973	6,294,191	319,070	259,503
5.	Radiology - Diagnostic	304,945	25,363,749	0.012023	2,196,555	4,251,683	26,409	51,118
6.	Radiology - Therapeutic	1,968,249	30,143,874	0.065295	278,043	3,132,659	18,155	204,547
7.	Nuclear Medicine	246,079	5,457,462	0.045090	326,707	913,566	14,731	41,193
8.	Laboratory	8,088,305	236,413,809	0.034212	28,578,392	36,001,564	977,724	1,231,686
9.	Blood							
10.	Blood - Administration	1,389,966	27,241,251	0.051024	5,820,561	1,872,679	296,988	95,552
11.	Intravenous Therapy	469,909	504,960	0.930587		2,977		2,770
12.	Respiratory Therapy	1,456,801	25,650,065	0.056795	6,333,603	1,172,562	359,717	66,596
13.	Physical Therapy	407,677	13,919,181	0.029289	869,625	2,748,120	25,470	80,490
14.	Occupational Therapy	191,985	5,414,395	0.035458	345,127	478,912	12,238	16,981
15.	Speech Pathology	139,302	1,368,227	0.101812	299,651	287,261	30,508	29,247
16.	EKG	411,781	4,327,531	0.095154	590,300	475,705	56,169	45,265
17.	EEG	46,484	3,894,758	0.011935	738,392	174,998	8,813	2,089
18.	Med. / Surg. Supplies	3,790,232	189,883,568	0.019961	32,086,436	12,508,755	640,477	249,687
19.	Drugs Charged to Patients	8,996,103	228,597,888	0.039353	53,761,838	11,216,283	2,115,690	441,394
20.	Renal Dialysis	1,492,624	33,430,784	0.044648	1,783,954	3,518,507	79,650	157,094
21.	Ambulance							
22.	Ultrasound	280,242	9,865,402	0.028407	1,159,877	1,509,697	32,949	42,886
23.	Radiology Angiography	2,000,793	56,897,173	0.035165	5,884,655	3,519,439	206,934	123,761
24.	Radiology W. Harrison	133,406	10,520,129	0.012681	3,445	2,066,658	44	26,207
25.	CT Scan	1,399,480	49,452,001	0.028300	5,324,220	6,397,257	150,675	181,042
26.	MRI	1,149,722	32,855,150	0.034994	2,821,393	5,832,119	98,732	204,089
27.	Cardiac Catheterization	1,739,831	11,620,229	0.149724	1,172,213	1,392,714	175,508	208,523
28.	Lab Issue Typing	54,333	4,552,391	0.011935	204,195	408,611	2,437	4,877
29.	Lab Outreach	1,522,199	127,540,744	0.011935				
30.	Gastroenterology	253,590	21,247,603	0.011935	1,385,090	2,932,730	16,531	35,002
31.	Bone Marrow Transplant	6,440	539,564	0.011936	145,800	20,179	1,740	241
32.	Cardiac Services	249,699	20,921,588	0.011935	2,578,792	1,954,963	30,778	23,332
33.	Kidney Acquisition	344,739	11,221,593	0.030721	1,943,898		59,718	
34.	Liver Acquisition	242,468	4,124,564	0.058786	1,061,679		62,412	
35.	Pancreas Acquisition	23,672	1,983,440	0.011935	198,344		2,367	
36.	Islet Acquisition							
37.	Other Organ Acquisition	43,918		#DIV/0!				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,654,568	107,729,746	0.033923	129,533	34,454,745	4,394	1,168,808
44.	Emergency	2,037,342	63,583,041	0.032042	6,126,959	15,175,680	196,320	486,259
45.	Observation							
46.	Ancillary Total						7,318,162	6,763,388

* 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)

REVISED-PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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	5,961,657	78,091	76.34	23,807		1,817,426	
48.	Psych	839,069	13,783	60.88				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	953,515	6,621	144.01	1,246		179,436	
52.	Coronary Care Unit	795,696	4,527	175.77	1,100		193,347	
53.	Pediatric ICU	495,463	2,762	179.39	1,963		352,143	
54.	Neonatal ICU	1,707,255	12,121	140.85	6,800		957,780	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	141,774	4,238	33.45	2,595		86,803	
67.	Routine Total (lines 47-66)						3,586,935	
68.	Ancillary Total (from line 46)						7,318,162	6,763,388
69.	Total (Lines 67-68)						10,905,097	6,763,388

