

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 Hospital & Health Sciences		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: 07/01/2012	To: 06/30/2013

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 Hospital . 3098 for the cost report beginning 07/01/2012 and ending 06/30/2013 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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

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
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part I-Hospital									
1.	Adults and Pediatrics	337	114,610		67,684	59.06%		19,523	4.88
2.	Psych	53	19,345		13,753	71.09%		1,225	11.23
3.	Rehab	18	6,570		4,409	67.11%		320	13.78
4.	Other (Sub)								
5.	Intensive Care Unit	34	12,410		8,864	71.43%			
6.	Coronary Care Unit	19	6,935		4,720	68.06%			
7.	Pediatric ICU	12	4,380		1,640	37.44%			
8.	Neonatal ICU	52	18,980		12,306	64.84%			
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				3,887				
22.	Total	525	183,230		117,263	64.00%		21,068	5.38
23.	Observation Bed Days				5,337				

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program								
1.	Adults and Pediatrics			20,359			6,865	4.78
2.	Psych							
3.	Rehab							
4.	Other (Sub)							
5.	Intensive Care Unit			1,861				
6.	Coronary Care Unit			1,225				
7.	Pediatric ICU			1,347				
8.	Neonatal ICU			8,006				
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			2,143				
22.	Total			34,941	29.80%		6,865	4.78

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	132,843	496,893

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: 07/01/2012 To: 06/30/2013

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	43,870,237	111,713,450	0.392703	13,317,826	16,725,023	5,229,950	6,567,967
2.	Recovery Room	4,528,976	8,030,182	0.563994	736,027	1,640,450	415,115	925,204
3.	Delivery and Labor Room	11,170,010	19,307,448	0.578534	7,869,457	2,049,711	4,552,748	1,185,828
4.	Anesthesiology	3,528,815	44,583,315	0.079151	8,510,447	5,902,762	673,610	467,210
5.	Radiology - Diagnostic	6,807,085	28,188,733	0.241482	2,668,651	4,426,414	644,431	1,068,899
6.	Radiology - Therapeutic	10,414,782	27,414,820	0.379896	462,335	3,149,850	175,639	1,196,615
7.	Nuclear Medicine	1,641,308	5,022,508	0.326791	426,415	824,000	139,349	269,276
8.	Laboratory	38,384,051	245,386,497	0.156423	29,239,283	36,425,455	4,573,696	5,697,779
9.	Blood							
10.	Blood - Administration	7,543,515	28,755,520	0.262333	6,815,208	2,208,766	1,787,854	579,432
11.	Intravenous Therapy	2,648,833	5,162	513.140837		9,876		5,067,779
12.	Respiratory Therapy	5,788,530	25,730,008	0.224972	7,785,339	1,109,103	1,751,483	249,517
13.	Physical Therapy	7,536,811	15,902,170	0.473949	1,013,848	3,167,620	480,512	1,501,290
14.	Occupational Therapy	3,141,939	5,815,671	0.540254	260,830	581,669	140,914	314,249
15.	Speech Pathology	924,669	1,940,576	0.476492	378,553	594,360	180,377	283,208
16.	EKG	534,440	4,385,804	0.121857	585,384	420,323	71,333	51,219
17.	EEG	778,638	5,357,688	0.145331	1,215,451	392,822	176,643	57,089
18.	Med. / Surg. Supplies	57,610,584	202,493,993	0.284505	32,895,125	14,239,766	9,358,828	4,051,285
19.	Drugs Charged to Patients	60,495,381	234,392,415	0.258094	53,480,096	11,050,502	13,802,892	2,852,068
20.	Renal Dialysis	10,200,967	37,213,277	0.274122	1,539,628	3,183,413	422,046	872,644
21.	Ambulance							
22.	Ultrasound	2,109,841	9,876,403	0.213624	1,093,857	1,618,055	233,674	345,655
23.	Radiology Angiography	7,791,080	49,359,392	0.157844	4,818,495	3,940,416	760,571	621,971
24.	Radiology W. Harrison	2,344,860	10,078,384	0.232662	12,144	2,382,461	2,825	554,308
25.	CT Scan	4,762,317	50,633,915	0.094054	5,147,618	6,241,571	484,154	587,045
26.	MRI	3,987,478	35,473,634	0.112407	3,015,829	6,538,686	339,000	734,994
27.	Cardiac Catheterization	2,986,326	11,524,726	0.259123	1,078,811	1,002,412	279,545	259,748
28.	Lab Tissue Typing	2,297,051	5,268,837	0.435969	127,030	419,455	55,381	182,869
29.	Lab Outreach	12,758,363	107,263,494	0.118944				
30.	Gastroenterology	4,650,477	20,605,584	0.225690	1,427,443	2,784,000	322,160	628,321
31.	Bone Marrow Transplant	1,581,236	812,759	1.945516	212,273	37,312	412,981	72,591
32.	Cardiac Services	4,970,702	20,567,488	0.241678	2,420,502	1,782,202	584,982	430,719
33.	Kidney Acquisition	7,387,583	12,988,780	0.568767	1,948,317	92,777	1,108,138	52,768
34.	Liver Acquisition	1,864,741	2,603,275	0.716306	728,917		522,128	
35.	Pancreas Acquisition	1,463,694	2,395,013	0.611142	208,262		127,278	
36.	Islet & Other Acquisition	453,427	174,674	2.595847		29,500		76,577
37.								
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	78,573,937	108,100,293	0.726861	92,901	34,555,364	67,526	25,116,946
44.	Emergency	17,581,393	68,473,553	0.256762	6,924,617	15,233,248	1,777,979	3,911,319
45.	Observation	7,957,414	13,143,805	0.605412	276,107	4,073,433	167,158	2,466,105
46.	Total				198,733,026	188,832,777	51,822,900	69,300,494

* 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: 07/01/2012 To: 06/30/2013

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)	108,873,480	16,561,418	5,561,673	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	73,021	13,753	4,409	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,490.99	1,204.20	1,261.44	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	20,359			
3.	Program general inpatient routine cost (Line 1c X Line 2)	30,355,065			
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)	30,355,065			

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	24,159,822	8,864	2,725.61	1,861	5,072,360
9.	Coronary Care Unit	13,302,613	4,720	2,818.35	1,225	3,452,479
10.	Pediatric ICU	5,997,807	1,640	3,657.20	1,347	4,926,248
11.	Neonatal ICU	24,117,063	12,306	1,959.78	8,006	15,689,999
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,672,544	3,887	944.83	2,143	2,024,771
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					51,822,900
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					113,343,822

**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: 07/01/2012 To: 06/30/2013

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

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 Tissue Typing							
29.	Lab Outreach							
30.	Gastroenterology							
31.	Bone Marrow Transplant							
32.	Cardiac Services							
33.	Kidney Acquisition							
34.	Liver Acquisition							
35.	Pancreas Acquisition							
36.	Islet & Other Acquisition							
37.								
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: 07/01/2012 To: 06/30/2013

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**

PRELIMINARY

Medicare Provider Number: 14-0150		Medicaid Provider Number: 3098	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2012 To: 06/30/2013	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		69,300,494
2.	Inpatient Operating Services (BHF Page 4, Line 25)	113,343,822	
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)	13,596,306	7,961,610
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	126,940,128	77,262,104
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	62.00%	38.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	198,733,026	188,832,777
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	41,029,998	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,483,606	
	F. Coronary Care Unit	4,745,717	
	G. Pediatric ICU	5,560,886	
	H. Neonatal ICU	27,505,290	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,032,805	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	283,091,328	188,832,777
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		267,212,873
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: 07/01/2012 To: 06/30/2013

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)	126,940,128	77,262,104
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	126,940,128	77,262,104
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)	126,940,128	77,262,104

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.

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

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)	267,721,873
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: 07/01/2012 To: 06/30/2013

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)

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2012 To: 06/30/2013

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	8,796,627	111,713,450	0.078743	13,317,826	16,725,023	1,048,686	1,316,978
2.	Recovery Room	97,029	8,030,182	0.012083	736,027	1,640,450	8,893	19,822
3.	Delivery and Labor Room	1,256,867	19,307,448	0.065098	7,869,457	2,049,711	512,286	133,432
4.	Anesthesiology	2,183,320	44,583,315	0.048972	8,510,447	5,902,762	416,774	289,070
5.	Radiology - Diagnostic	340,604	28,188,733	0.012083	2,668,651	4,426,414	32,245	53,484
6.	Radiology - Therapeutic	2,435,907	27,414,820	0.088854	462,335	3,149,850	41,080	279,877
7.	Nuclear Medicine	290,704	5,022,508	0.057880	426,415	824,000	24,681	47,693
8.	Laboratory	9,858,843	245,386,497	0.040177	29,239,283	36,425,455	1,174,747	1,463,466
9.	Blood							
10.	Blood - Administration	1,739,055	28,755,520	0.060477	6,815,208	2,208,766	412,163	133,580
11.	Intravenous Therapy	62	5,162	0.012011		9,876		119
12.	Respiratory Therapy	1,817,506	25,730,008	0.070638	7,785,339	1,109,103	549,941	78,345
13.	Physical Therapy	508,419	15,902,170	0.031972	1,013,848	3,167,620	32,415	101,275
14.	Occupational Therapy	237,033	5,815,671	0.040758	260,830	581,669	10,631	23,708
15.	Speech Pathology	184,460	1,940,576	0.095054	378,553	594,360	35,983	56,496
16.	EKG	524,528	4,385,804	0.119597	585,384	420,323	70,010	50,269
17.	EEG	64,737	5,357,688	0.012083	1,215,451	392,822	14,686	4,746
18.	Med. / Surg. Supplies	4,442,131	202,493,993	0.021937	32,895,125	14,239,766	721,620	312,378
19.	Drugs Charged to Patients	11,949,448	234,392,415	0.050981	53,480,096	11,050,502	2,726,469	563,366
20.	Renal Dialysis	1,421,469	37,213,277	0.038198	1,539,628	3,183,413	58,811	121,600
21.	Ambulance							
22.	Ultrasound	332,103	9,876,403	0.033626	1,093,857	1,618,055	36,782	54,409
23.	Radiology Angiography	2,304,285	49,359,392	0.046684	4,818,495	3,940,416	224,947	183,954
24.	Radiology W. Harrison	121,777	10,078,384	0.012083	12,144	2,382,461	147	28,787
25.	CT Scan	1,606,633	50,633,915	0.031730	5,147,618	6,241,571	163,334	198,045
26.	MRI	1,400,449	35,473,634	0.039479	3,015,829	6,538,686	119,062	258,141
27.	Cardiac Catheterization	2,232,406	11,524,726	0.193706	1,078,811	1,002,412	208,972	194,173
28.	Lab Tissue Typing	63,663	5,268,837	0.012083	127,030	419,455	1,535	5,068
29.	Lab Outreach	1,296,065	107,263,494	0.012083				
30.	Gastroenterology	248,977	20,605,584	0.012083	1,427,443	2,784,000	17,248	33,639
31.	Bone Marrow Transplant	9,821	812,759	0.012084	212,273	37,312	2,565	451
32.	Cardiac Services	248,517	20,567,488	0.012083	2,420,502	1,782,202	29,247	21,534
33.	Kidney Acquisition	432,963	12,988,780	0.033334	1,948,317	92,777	64,945	3,093
34.	Liver Acquisition	284,473	2,603,275	0.109275	728,917		79,652	
35.	Pancreas Acquisition	28,939	2,395,013	0.012083	208,262		2,516	
36.	Islet & Other Acquisition	59,614	174,674	0.341287		29,500		10,068
37.								
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	4,267,640	108,100,293	0.039479	92,901	34,555,364	3,668	1,364,211
44.	Emergency	2,500,738	68,473,553	0.036521	6,924,617	15,233,248	252,894	556,333
45.	Observation							
46.	Ancillary Total						9,099,635	7,961,610

* 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: 07/01/2012 To: 06/30/2013

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	7,226,007	73,021	98.96	20,359		2,014,727	
48.	Psych	1,034,046	13,753	75.19				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,285,685	8,864	145.05	1,861		269,938	
52.	Coronary Care Unit	999,278	4,720	211.71	1,225		259,345	
53.	Pediatric ICU	572,248	1,640	348.93	1,347		470,009	
54.	Neonatal ICU	2,139,705	12,306	173.87	8,006		1,392,003	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	164,404	3,887	42.30	2,143		90,649	
67.	Routine Total (lines 47-66)						4,496,671	
68.	Ancillary Total (from line 46)						9,099,635	7,961,610
69.	Total (Lines 67-68)						13,596,306	7,961,610

