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: Northwestern Memorial Hospital		**Medicare Provider Number:** 14-0281
Street: 251 W. Huron		**Medicaid Provider Number:** 3122
City: Chicago	**State:** Illinois	**Zip:** 60611
Period Covered by Statement:	**From:** 09/01/2009	**To:** 08/31/2010

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX	General Short-Term		Psychiatric		Cancer
	General Long-Term		Rehabilitation		Other (Specify)

Health Care Program

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

	Medicaid Hospital		Medicaid Sub II		DHS - Office of Rehabilitation Services
XXXX	Medicaid Sub I Psychiatric		Medicaid Sub III		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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/2009 and ending 08/31/2010 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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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	634	231,465		181,090	78.24%		47,552	4.57
2.	Psych	36	13,140		12,011	91.41%		1,400	8.58
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit	92	33,580		26,437	78.73%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,390		9,830	31.32%			
8.	Other								
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	114	41,610		41,459	99.64%			
22.	**Total**	**962**	**351,185**		**270,827**	**77.12%**		**48,952**	**4.69**
23.	Observation Bed Days				6,140				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				4,781			607	7.88
3.	Sub II								
4.	Sub III								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Special Care Nursery								
8.	Other								
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**				**4,781**	**1.77%**		**607**	**7.88**

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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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	94,790,726	559,303,935	0.169480				
2.	Recovery Room	8,538,156	25,609,757	0.333395	76,664		25,559	
3.	Delivery and Labor Room	34,774,774	127,848,005	0.272001				
4.	Anesthesiology	6,459,453	44,199,919	0.146142	4,161		608	
5.	Radiology - Diagnostic	77,547,525	535,376,459	0.144847	293,154		42,462	
6.	Radiology - Therapeutic	16,113,453	119,252,659	0.135120	5,833		788	
7.	Nuclear Medicine	8,379,652	67,329,401	0.124458				
8.	Laboratory	76,336,094	531,621,601	0.143591	1,558,204		223,744	
9.	Blood							
10.	Blood - Administration	31,201,332	83,482,908	0.373745	4,406		1,647	
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,154,703	128,619,928	0.102276	42,488		4,346	
13.	Physical Therapy	4,697,571	11,931,982	0.393696	12,726		5,010	
14.	Occupational Therapy	1,841,933	8,757,155	0.210335	8,368		1,760	
15.	Speech Pathology							
16.	EKG	6,359,342	29,505,590	0.215530	152,990		32,974	
17.	EEG	6,035,304	25,250,594	0.239016	55,197		13,193	
18.	Med. / Surg. Supplies	138,363,609	293,457,680	0.471494	16,582		7,818	
19.	Drugs Charged to Patients	48,826,204	235,828,176	0.207041	749,558		155,189	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	11,343,128	70,541,145	0.160802				
23.	Cardiology Graphics	8,738,197	60,884,424	0.143521	10,720		1,539	
24.	Pulmonary Funcation Testing	1,122,512	9,538,754	0.117679				
25.	MRI	20,781,068	164,428,751	0.126383	114,955		14,528	
26.	Blood Flow Lab	2,491,038	23,699,527	0.105109	8,040		845	
27.	Cellitrifuge	3,068,735	6,055,921	0.506733				
28.	Cast Room							
29.	GI Lab	14,725,113	70,374,887	0.209238	2,535		530	
30.	Solid Organ Transplant	6,883,543	7,772,373	0.885642				
31.	Transplant Acq (Liver/Kidney/Heart/P	23,946,169	35,860,975	0.667750				
32.	OB & STD/Aids Clinic	12,804,813	19,595,740	0.653449	703		459	
33.								
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	9,690,725	11,258,415	0.860754	452,621		389,595	
44.	Emergency	29,994,905	164,756,059	0.182056	1,297,148		236,154	
45.	Observation	1,170,435	803,547	1.456586				
46.	**Total**				**4,867,053**		**1,158,748**	

* 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:	Medicaid Provider Number:		
14-0281	3122		
Program:	**Period Covered by Statement:**		
Medicaid-Psychiatric	From: 09/01/2009	To:	08/31/2010

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Sub II	Sub III Sub III
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	237,580,726	10,769,135		
b)	Total inpatient days including private room days (CMS 2552, W/S S-3, Part 1, Col. 6)	187,230	12,011		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,268.92	896.61		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		4,781		
3.	Program general inpatient routine cost (Line 1c X Line 2)		4,286,692		
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)		4,286,692		

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	62,308,990	26,437	2,356.89		
9.	Coronary Care Unit					
10.	Special Care Nursery	23,472,989	9,830	2,387.89		
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	19,463,996	41,459	469.48		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,158,748
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,445,440**

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Sub II						
5.	Sub III						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Special Care Nursery						
9.	Other						
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 Assign-able Time (CMS 2552, W/S D-2, Col. 1)	Expense Alloca-tion (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	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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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.	Cardiac Cath Lab							
23.	Cardiology Graphics							
24.	Pulmonary Funcation Testing							
25.	MRI							
26.	Blood Flow Lab							
27.	Cellitrifuge							
28.	Cast Room							
29.	GI Lab							
30.	Solid Organ Transplant							
31.	Transplant Acq (Liver/Kidney/Heart/Par							
32.	OB & STD/Aids Clinic							
33.								
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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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.	Sub II							
50.	Sub III							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Special Care Nursery							
54.	Other							
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)**							

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	5,445,440	
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)	858,050	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**6,303,490**	
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	4,867,053	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	10,027,937	
	C. Sub II		
	D. Sub III		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Special Care Nursery		
	H. Other		
	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)**	14,894,990	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		8,591,500
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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	6,303,490	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,303,490	
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)**	**6,303,490**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

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Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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)	8,591,500
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	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0281	**3122**
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	**From: 09/01/2009 To: 08/31/2010**

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 Sub II**	**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 Sub II**	**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 Sub II**	**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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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	15,512,161	559,303,935	0.027735				
2.	Recovery Room	718,737	25,609,757	0.028065	76,664		2,152	
3.	Delivery and Labor Room	2,560,937	127,848,005	0.020031				
4.	Anesthesiology	104,671	44,199,919	0.002368	4,161		10	
5.	Radiology - Diagnostic	4,703,192	535,376,459	0.008785	293,154		2,575	
6.	Radiology - Therapeutic	1,500,276	119,252,659	0.012581	5,833		73	
7.	Nuclear Medicine	202,362	67,329,401	0.003006				
8.	Laboratory	3,830,938	531,621,601	0.007206	1,558,204		11,228	
9.	Blood							
10.	Blood - Administration	293,078	83,482,908	0.003511	4,406		15	
11.	Intravenous Therapy							
12.	Respiratory Therapy	202,362	128,619,928	0.001573	42,488		67	
13.	Physical Therapy	20,934	11,931,982	0.001754	12,726		22	
14.	Occupational Therapy	20,934	8,757,155	0.002391	8,368		20	
15.	Speech Pathology							
16.	EKG							
17.	EEG	167,473	25,250,594	0.006632	55,197		366	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	404,726	70,541,145	0.005737				
23.	Cardiology Graphics	621,045	60,884,424	0.010200	10,720		109	
24.	Pulmonary Funcation Testing	202,362	9,538,754	0.021215				
25.	MRI							
26.	Blood Flow Lab	20,934	23,699,527	0.000883	8,040		7	
27.	Cellitrifuge							
28.	Cast Room							
29.	GI Lab	390,769	70,374,887	0.005553	2,535		14	
30.	Solid Organ Transplant							
31.	Transplant Acq (Liver/Kidney/Heart/F							
32.	OB & STD/Aids Clinic	1,200,221	19,595,740	0.061249	703		43	
33.								
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	1,786,376	11,258,415	0.158670	452,621		71,817	
44.	Emergency	2,135,277	164,756,059	0.012960	1,297,148		16,811	
45.	Observation							
46.	**Ancillary Total**						**105,329**	

* 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:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2009 To: 08/31/2010

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	16,105,296	187,230	86.02				
48.	Psych	1,891,047	12,011	157.44	4,781		752,721	
49.	Sub II							
50.	Sub III							
51.	Intensive Care Unit	6,831,492	26,437	258.41				
52.	Coronary Care Unit							
53.	Special Care Nursery	376,814	9,830	38.33				
54.	Other							
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)**						**752,721**	
68.	**Ancillary Total (from line 46)**						**105,329**	
69.	**Total (Lines 67-68)**						**858,050**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0281	**3122**
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	**From: 09/01/2009 To: 08/31/2010**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	4,781		4,781
Newborn Days			
Total Inpatient Revenue	14,894,990		14,894,990
Ancillary Revenue	4,867,053		4,867,053
Routine Revenue	10,027,937		10,027,937
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 Costs were adjusted to filed W/S C, Pt 1, Col 1.
GME Costs were adjusted to filed W/S B, Pt 1, Col 26.
Transplant Acq Costs are taken from filed W/S B, Pt 1, Col 25.
Transplant Acq Charges are greater than filed W/S D-6, Pt III & IV, Line 51.
Observation Bed Days on BHF Page 2 came from W/S S-3 Column 6, Line 26.
Included Implant Devices Costs & Charges with Medical Supplies