Hospital Statement of Cost

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

General Information

PRELIMINARY

Name of Hospital: University of Illinois Medical Center at Chicago		**Medicare Provider Number:** 14-0150	
Street: 1740 W. Taylor Street		**Medicaid Provider Number:** 3098	
City: Chicago	**State:** Illinois	**Zip:** 60612	
Period Covered by Statement:	**From:** 07/01/2010	**To:** 06/30/2011	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
[ ]	Church	[ ]	Individual	[XXXX]	State	[ ]	Township
[ ]	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)

[XXXX]	Medicaid Hospital	[ ]	Medicaid Sub II Rehab	[ ]	DHS - Office of Rehabilitation Services
[ ]	Medicaid Sub I Psych	[ ]	Medicaid Sub III Other	[ ]	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 07/01/2010 and ending 06/30/2011 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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	301	109,865		69,116	62.91%		18,424	5.19
2.	Psych	45	17,845		13,398	75.08%		1,123	11.93
3.	Rehab	17	6,205		3,870	62.37%		344	11.25
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,030		5,802	72.25%			
6.	Coronary Care Unit	19	6,935		5,290	76.28%			
7.	Pediatric ICU	21	7,665		4,174	54.46%			
8.	Neonatal ICU	58	21,170		11,193	52.87%			
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		4,219	46.24%			
22.	**Total**	**508**	**186,840**		**117,062**	**62.65%**		**19,891**	**5.67**
23.	Observation Bed Days				5,700				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				22,885			6,869	4.96
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,057				
6.	Coronary Care Unit				1,086				
7.	Pediatric ICU				1,784				
8.	Neonatal ICU				7,264				
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				2,442				
22.	**Total**				**36,518**	**31.20%**		**6,869**	**4.96**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	130,152	486,828

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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	32,605,099	91,196,511	0.357526	10,145,800	14,607,176	3,627,387	5,222,445
2.	Recovery Room	2,860,155	6,788,299	0.421336	603,034	1,443,329	254,080	608,126
3.	Delivery and Labor Room	12,653,418	24,278,490	0.521178	11,466,723	2,087,651	5,976,204	1,088,038
4.	Anesthesiology	2,821,064	41,246,230	0.068396	7,942,662	5,394,216	543,246	368,943
5.	Radiology - Diagnostic	7,974,986	20,759,584	0.384159	2,084,823	3,444,150	800,904	1,323,101
6.	Radiology - Therapeutic	8,656,915	30,451,300	0.284287	364,046	3,472,462	103,494	987,176
7.	Nuclear Medicine	1,639,016	6,117,881	0.267906	379,821	918,025	101,756	245,944
8.	Laboratory	33,414,266	214,346,287	0.155889	27,454,486	32,733,283	4,279,852	5,102,759
9.	Blood							
10.	Blood - Administration	7,743,144	26,155,118	0.296047	5,757,360	1,849,977	1,704,449	547,680
11.	Intravenous Therapy	13,460,120	31,277,457	0.430346		3,093		1,331
12.	Respiratory Therapy	5,056,263	23,912,318	0.211450	6,443,115	1,100,174	1,362,397	232,632
13.	Physical Therapy	5,353,167	10,996,499	0.486806	807,701	2,092,722	393,194	1,018,750
14.	Occupational Therapy	2,279,676	4,752,822	0.479647	308,310	453,534	147,880	217,536
15.	Speech Pathology	734,055	1,395,842	0.525887	246,478	305,738	129,620	160,784
16.	EKG	446,192	4,081,220	0.109328	492,464	446,882	53,840	48,857
17.	EEG	730,993	4,282,322	0.170700	800,487	173,150	136,643	29,557
18.	Med. / Surg. Supplies	56,142,474	168,682,026	0.332830	31,429,475	11,177,163	10,460,672	3,720,095
19.	Drugs Charged to Patients	45,314,601	157,559,663	0.287603	43,018,612	10,667,069	12,372,282	3,067,881
20.	Renal Dialysis	8,752,066	29,063,348	0.301138	1,464,342	4,091,846	440,969	1,232,210
21.	Ambulance							
22.	Ultrasound	1,588,031	9,054,655	0.175383	1,054,407	1,491,018	184,925	261,499
23.	Radio Angiography	6,098,343	55,242,540	0.110392	5,000,065	4,291,182	551,967	473,712
24.	Radio W. Harrison	1,129,661	5,351,492	0.211093		445,317		94,003
25.	CT Scan	3,954,648	48,638,298	0.081307	4,766,452	6,146,092	387,546	499,720
26.	MRI	2,378,243	32,285,969	0.073662	2,314,947	6,124,790	170,524	451,164
27.	Cardiac Catheterization	2,595,150	10,382,415	0.249956	978,905	972,279	244,683	243,027
28.	Lab Issue Typing	841,298	2,028,603	0.414718	120,258	103,705	49,873	43,008
29.	Lab Outreach	15,372,489	122,154,732	0.125844				
30.	Gastroenterology	3,474,159	18,969,759	0.183142	1,199,545	2,364,027	219,687	432,953
31.	Bone Marrow Transplant	1,076,690	580,229	1.855629	211,585	26,565	392,623	49,295
32.	Cardiac Services	4,069,717	18,190,866	0.223723	2,669,217	1,625,313	597,165	363,620
33.	Kidney Acquisition	7,089,114	10,587,327	0.669585	1,568,982		1,050,567	
34.	Liver Acquisition	2,579,622	4,254,246	0.606364	824,938	92,684	500,213	56,200
35.	Pancreas Acquisition	832,989	1,255,709	0.663361	185,368		122,966	
36.	Islet Acquisition	316,585	53,901	5.873453				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	65,510,378	101,974,856	0.642417	151,904	30,535,398	97,586	19,616,459
44.	Emergency	15,074,559	54,802,524	0.275071	5,564,809	13,184,245	1,530,718	3,626,603
45.	Observation	7,350,492	12,890,987	0.570204	510,218	3,256,784	290,928	1,857,031
46.	**Total**				**178,331,339**	**167,121,039**	**49,280,840**	**53,292,139**

* 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:			
14-0150	3098			
Program:	**Period Covered by Statement:**			
Medicaid-Hospital	From:	07/01/2010	To:	06/30/2011

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)	96,479,645	14,795,029	3,659,095	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,816	13,398	3,870	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,289.56	1,104.27	945.50	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	22,885			
3.	Program general inpatient routine cost (Line 1c X Line 2)	29,511,581			
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)	29,511,581			

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	13,755,705	5,802	2,370.86	1,057	2,505,999
9.	Coronary Care Unit	13,111,048	5,290	2,478.46	1,086	2,691,608
10.	Pediatric ICU	9,766,453	4,174	2,339.83	1,784	4,174,257
11.	Neonatal ICU	19,596,855	11,193	1,750.81	7,264	12,717,884
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,483,333	4,219	588.61	2,442	1,437,386
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					49,280,840
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**102,319,555**

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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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.	Radio Angiography							
24.	Radio 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							
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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		53,292,139
2.	Inpatient Operating Services (BHF Page 4, Line 25)	102,319,555	
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)	10,464,584	6,274,865
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**112,784,139**	**59,567,004**
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 (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	178,331,339	167,121,039
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	37,529,272	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,645,577	
	F. Coronary Care Unit	3,755,021	
	G. Pediatric ICU	6,129,236	
	H. Neonatal ICU	21,916,278	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,076,300	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	253,383,023	167,121,039
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		248,152,919
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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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)	112,784,139	59,567,004
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	112,784,139	59,567,004
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)**	**112,784,139**	**59,567,004**

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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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)	248,152,919
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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:**
14-0150	**3098**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2010 To: 06/30/2011**

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:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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	6,352,185	91,196,511	0.069654	10,145,800	14,607,176	706,696	1,017,448
2.	Recovery Room	80,740	6,788,299	0.011894	603,034	1,443,329	7,172	17,167
3.	Delivery and Labor Room	1,012,794	24,278,490	0.041716	11,466,723	2,087,651	478,346	87,088
4.	Anesthesiology	1,653,906	41,246,230	0.040098	7,942,662	5,394,216	318,485	216,297
5.	Radiology - Diagnostic	246,914	20,759,584	0.011894	2,084,823	3,444,150	24,797	40,965
6.	Radiology - Therapeutic	1,850,916	30,451,300	0.060783	364,046	3,472,462	22,128	211,067
7.	Nuclear Medicine	235,469	6,117,881	0.038489	379,821	918,025	14,619	35,334
8.	Laboratory	7,426,480	214,346,287	0.034647	27,454,486	32,733,283	951,216	1,134,110
9.	Blood							
10.	Blood - Administration	1,295,439	26,155,118	0.049529	5,757,360	1,849,977	285,156	91,628
11.	Intravenous Therapy	372,014	31,277,457	0.011894		3,093		37
12.	Respiratory Therapy	1,350,114	23,912,318	0.056461	6,443,115	1,100,174	363,785	62,117
13.	Physical Therapy	354,508	10,996,499	0.032238	807,701	2,092,722	26,039	67,465
14.	Occupational Therapy	174,489	4,752,822	0.036713	308,310	453,534	11,319	16,651
15.	Speech Pathology	130,494	1,395,842	0.093488	246,478	305,738	23,043	28,583
16.	EKG	382,082	4,081,220	0.093620	492,464	446,882	46,104	41,837
17.	EEG	50,934	4,282,322	0.011894	800,487	173,150	9,521	2,059
18.	Med. / Surg. Supplies	3,417,748	168,682,026	0.020261	31,429,475	11,177,163	636,793	226,460
19.	Drugs Charged to Patients	8,321,103	157,559,663	0.052812	43,018,612	10,667,069	2,271,899	563,349
20.	Renal Dialysis	1,569,633	29,063,348	0.054007	1,464,342	4,091,846	79,085	220,988
21.	Ambulance							
22.	Ultrasound	258,196	9,054,655	0.028515	1,054,407	1,491,018	30,066	42,516
23.	Radio Angiography	1,865,121	55,242,540	0.033762	5,000,065	4,291,182	168,812	144,879
24.	Radio W. Harrison	63,651	5,351,492	0.011894		445,317		5,297
25.	CT Scan	1,282,192	48,638,298	0.026362	4,766,452	6,146,092	125,653	162,023
26.	MRI	1,071,427	32,285,969	0.033186	2,314,947	6,124,790	76,824	203,257
27.	Cardiac Catheterization	1,604,081	10,382,415	0.154500	978,905	972,279	151,241	150,217
28.	Lab Issue Typing	24,128	2,028,603	0.011894	120,258	103,705	1,430	1,233
29.	Lab Outreach	1,452,908	122,154,732	0.011894				
30.	Gastroenterology	225,626	18,969,759	0.011894	1,199,545	2,364,027	14,267	28,118
31.	Bone Marrow Transplant	6,901	580,229	0.011894	211,585	26,565	2,517	316
32.	Cardiac Services	216,362	18,190,866	0.011894	2,669,217	1,625,313	31,748	19,331
33.	Kidney Acquisition	321,169	10,587,327	0.030335	1,568,982		47,595	
34.	Liver Acquisition	229,573	4,254,246	0.053963	824,938	92,684	44,516	5,002
35.	Pancreas Acquisition	14,935	1,255,709	0.011894	185,368		2,205	
36.	Islet Acquisition	641	53,901	0.011892				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,307,683	101,974,856	0.032436	151,904	30,535,398	4,927	990,446
44.	Emergency	1,835,482	54,802,524	0.033493	5,564,809	13,184,245	186,382	441,580
45.	Observation							
46.	**Ancillary Total**						**7,164,386**	**6,274,865**

* 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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

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	5,478,545	74,816	73.23	22,885		1,675,869	
48.	Psych	772,517	13,398	57.66				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	857,153	5,802	147.73	1,057		156,151	
52.	Coronary Care Unit	770,987	5,290	145.74	1,086		158,274	
53.	Pediatric ICU	519,880	4,174	124.55	1,784		222,197	
54.	Neonatal ICU	1,557,724	11,193	139.17	7,264		1,010,931	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	132,664	4,219	31.44	2,442		76,776	
67.	**Routine Total (lines 47-66)**						**3,300,198**	
68.	**Ancillary Total (from line 46)**						**7,164,386**	**6,274,865**
69.	**Total (Lines 67-68)**						**10,464,584**	**6,274,865**

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	34,076		34,076
Newborn Days	2,442		2,442
Total Inpatient Revenue	253,383,023		253,383,023
Ancillary Revenue	178,331,339		178,331,339
Routine Revenue	75,051,684		75,051,684
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	130,152		130,152
Total Outpatient Revenue	167,121,039		167,121,039
Outpatient Received and Receivable			

Notes:

Nursery Beds and Days Available came from prior year Medicaid report.
Reclassified Blood charges as Blood Admin.
BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1.
Clinic costs and charges include Medicare lines 93.01, 93.02, and 93.03.
GME Costs were adjusted to filed W/S B, Pt 1, Col 25.

Filed report did not list all ancillary cost centers but BHF could trace to Medicare report.