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 E. Huron		**Medicaid Provider Number:** 3122
City: Chicago	**State:** Illinois	**Zip:** 60611
Period Covered by Statement:	**From:** 09/01/2010	**To:** 08/31/2011

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)

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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/2010 and ending 08/31/2011 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:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 09/01/2010 To: 08/31/2011

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	654	237,102		178,575	75.32%		50,495	4.58
2.	Psych	36	13,140		11,204	85.27%		1,365	8.21
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	91	32,879		30,112	91.58%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,390		22,566	71.89%			
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		26,226	63.03%			
22.	**Total**	**981**	**356,121**		**268,683**	**75.45%**		**51,860**	**4.68**
23.	Observation Bed Days				6,616				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				26,180			8,004	4.61
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				3,804				
6.	Coronary Care Unit								
7.	Special Care Nursery				6,883				
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				4,392				
22.	**Total**				**41,259**	**15.36%**		**8,004**	**4.61**

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-Hospital	From: 09/01/2010 To: 08/31/2011

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	83,634,705	586,564,133	0.142584	29,613,892		4,222,467	
2.	Recovery Room	15,751,613	65,123,820	0.241872	1,747,042		422,561	
3.	Delivery and Labor Room	35,100,987	138,326,519	0.253755	24,476,791		6,211,108	
4.	Anesthesiology	7,855,944	49,389,327	0.159062	2,462,309		391,660	
5.	Radiology - Diagnostic	59,936,623	257,693,766	0.232589	13,345,995		3,104,132	
6.	Radiology - Therapeutic	16,907,442	143,440,098	0.117871	990,078		116,701	
7.	Nuclear Medicine	10,253,554	66,372,738	0.154484	1,218,050		188,169	
8.	Laboratory	76,143,538	584,304,423	0.130315	41,255,155		5,376,166	
9.	Blood							
10.	Blood - Administration	19,485,548	74,059,941	0.263105	8,385,487		2,206,264	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,585,423	138,554,009	0.119704	20,020,732		2,396,562	
13.	Physical Therapy	4,303,391	12,378,150	0.347660	1,463,829		508,915	
14.	Occupational Therapy	1,732,211	7,821,335	0.221473	677,573		150,064	
15.	Speech Pathology							
16.	EKG	4,589,230	27,677,876	0.165809	1,404,274		232,841	
17.	EEG	5,241,647	28,754,727	0.182288	1,853,216		337,819	
18.	Med. / Surg. Supplies	53,576,445	160,570,797	0.333662	10,335,134		3,448,441	
19.	Drugs Charged to Patients	62,433,005	275,389,631	0.226708	24,518,215		5,558,475	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	5,654,878	50,455,917	0.112076	2,527,566		283,279	
23.	Cardiology Graphics	7,311,942	63,306,313	0.115501	3,939,457		455,011	
24.	Pulmonary Funcation Testing	1,165,323	10,261,922	0.113558	190,613		21,646	
25.	MRI	17,489,620	170,557,753	0.102544	4,543,565		465,915	
26.	Vascular Lab & Cell Therapy	3,576,924	25,815,423	0.138558	1,699,490		235,478	
27.	CT & EPS	16,568,430	264,235,175	0.062703	11,910,481		746,823	
28.	Cast Room							
29.	GI Lab	15,130,542	73,855,803	0.204866	1,054,816		216,096	
30.	Transplant Clinic	2,717,873	8,904,761	0.305216	40,456		12,348	
31.	Transplant Acq (Liver/Kidney/Heart/P	22,273,290	39,698,686	0.561059	2,309,600		1,295,822	
32.	OB & Psych Clinic	14,094,741	14,116,157	0.998483	48,759		48,685	
33.	Blood Flow Lab	7,552,535	31,859,830	0.237055	2,621,407		621,418	
34.	Implantable Devices	66,993,266	171,743,207	0.390078	8,969,113		3,498,654	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	4,878,186	3,628,438	1.344431	4,576		6,152	
44.	Emergency	29,635,871	161,998,558	0.182939	8,958,016		1,638,770	
45.	Observation	2,308,276	6,099,581	0.378432				
46.	**Total**				**232,585,687**		**44,418,442**	

* 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-Hospital	From: 09/01/2010	To:	08/31/2011

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)	226,133,534	8,000,130		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	185,191	11,204		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,221.08	714.04		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	26,180			
3.	Program general inpatient routine cost (Line 1c X Line 2)	31,967,874			
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)	31,967,874			

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	57,614,832	30,112	1,913.35	3,804	7,278,383
9.	Coronary Care Unit					
10.	Special Care Nursery	30,101,214	22,566	1,333.92	6,883	9,181,371
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	5,446,526	26,226	207.68	4,392	912,131
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					44,418,442
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**93,758,201**

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-Hospital	From: 09/01/2010 To: 08/31/2011

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.	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 2552-10, 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:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 09/01/2010 To: 08/31/2011

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.	Cardiac Cath Lab							
23.	Cardiology Graphics							
24.	Pulmonary Funcation Testing							
25.	MRI							
26.	Vascular Lab & Cell Therapy							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab							
30.	Transplant Clinic							
31.	Transplant Acq (Liver/Kidney/Heart/Par							
32.	OB & Psych Clinic							
33.	Blood Flow Lab							
34.	Implantable Devices							
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-Hospital	From: 09/01/2010 To: 08/31/2011

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.	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)**							

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-Hospital	From: 09/01/2010 To: 08/31/2011

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)	93,758,201	
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)	4,694,802	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**98,453,003**	
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)	232,585,687	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	62,295,133	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	16,560,840	
	F. Coronary Care Unit		
	G. Special Care Nursery	29,816,911	
	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	4,393,225	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	345,651,796	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		247,198,793
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-Hospital	From: 09/01/2010 To: 08/31/2011

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)	98,453,003	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	98,453,003	
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)**	**98,453,003**	

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:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 09/01/2010 To: 08/31/2011

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)	247,198,793
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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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-Hospital	**From: 09/01/2010 To: 08/31/2011**

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:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 09/01/2010 To: 08/31/2011

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	13,698,242	586,564,133	0.023353	29,613,892		691,573	
2.	Recovery Room	634,691	65,123,820	0.009746	1,747,042		17,027	
3.	Delivery and Labor Room	2,261,473	138,326,519	0.016349	24,476,791		400,171	
4.	Anesthesiology	92,430	49,389,327	0.001871	2,462,309		4,607	
5.	Radiology - Diagnostic	4,153,223	257,693,766	0.016117	13,345,995		215,097	
6.	Radiology - Therapeutic	1,324,841	143,440,098	0.009236	990,078		9,144	
7.	Nuclear Medicine	178,700	66,372,738	0.002692	1,218,050		3,279	
8.	Laboratory	3,382,967	584,304,423	0.005790	41,255,155		238,867	
9.	Blood							
10.	Blood - Administration	258,806	74,059,941	0.003495	8,385,487		29,307	
11.	Intravenous Therapy							
12.	Respiratory Therapy	178,700	138,554,009	0.001290	20,020,732		25,827	
13.	Physical Therapy	18,486	12,378,150	0.001493	1,463,829		2,185	
14.	Occupational Therapy	18,486	7,821,335	0.002364	677,573		1,602	
15.	Speech Pathology							
16.	EKG							
17.	EEG	147,890	28,754,727	0.005143	1,853,216		9,531	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	357,399	50,455,917	0.007083	2,527,566		17,903	
23.	Cardiology Graphics	548,423	63,306,313	0.008663	3,939,457		34,128	
24.	Pulmonary Funcation Testing	203,348	10,261,922	0.019816	190,613		3,777	
25.	MRI							
26.	Vascular Lab & Cell Therapy							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab	345,075	73,855,803	0.004672	1,054,816		4,928	
30.	Transplant Clinic	308,103	8,904,761	0.034600	40,456		1,400	
31.	Transplant Acq (Liver/Kidney/Heart/F							
32.	OB & Psych Clinic	1,367,976	14,116,157	0.096909	48,759		4,725	
33.	Blood Flow Lab							
34.	Implantable Devices							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	961,280	3,628,438	0.264929	4,576		1,212	
44.	Emergency	1,885,588	161,998,558	0.011640	8,958,016		104,271	
45.	Observation							
46.	**Ancillary Total**						**1,820,561**	

* 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-Hospital	From: 09/01/2010 To: 08/31/2011

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	14,222,013	185,191	76.80	26,180		2,010,624	
48.	Psych	1,669,916	11,204	149.05				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	6,032,649	30,112	200.34	3,804		762,093	
52.	Coronary Care Unit							
53.	Special Care Nursery	332,751	22,566	14.75	6,883		101,524	
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)**						**2,874,241**	
68.	**Ancillary Total (from line 46)**						**1,820,561**	
69.	**Total (Lines 67-68)**						**4,694,802**	

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-Hospital	From: 09/01/2010 To: 08/31/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	36,867		36,867
Newborn Days	4,392		4,392
Total Inpatient Revenue	345,651,796		345,651,796
Ancillary Revenue	232,585,687		232,585,687
Routine Revenue	113,066,109		113,066,109
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 25.
Observation Bed Days on BHF Page 2 came from W/S S-3 Column 6, Line 26.
Blood on BHF Page 3 is reclassified as Blood-Administration.
Blood-Administration on BHF Page 3 is reclassified as Blood Flow Lab to agree with prior year.
Blood on BHF Page 3 is reclassified as Blood-Administration.
Blood-Administration on BHF Page 3 is reclassified as Blood Flow Lab to agree with prior year.
Solid Organ Transplant on BHF Page is reclassified to Transplant Clinic to agree with W/S C.