

Hospital Statement of Cost

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

General Information Preliminary-Revised

Name of Hospital: Central DuPage Hospital		Medicare Provider Number: 14-0242	
Street: 25 North Winfield Road		Medicaid Provider Number: 23008	
City: Winfield	State: Illinois	Zip: 60190	
Period Covered by Statement:	From: 07/01/2011	To: 06/30/2012	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input 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 checked="" type="checkbox"/> Other (Specify) Board of Trustees	<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)) Central DuPage Hospital 23008 for the cost report beginning 07/01/2011 and ending 06/30/2012 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

 Name (Typewritten)
 Title _____ Date _____
 Firm _____
 Telephone Number _____
 Email Address _____

 Name (Typewritten)
 Title _____
 Date _____
 Telephone Number _____
 Email Address _____

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

Preliminary-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	273	99,918		68,934	68.99%	22,186	22,186	3.57
2.	Psych	15	5,490		5,179	94.34%	743	743	6.97
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,052		5,891	73.16%			
6.	Coronary Care Unit	16	5,856		4,300	73.43%			
7.	Other								
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	62	22,630		13,845	61.18%			
22.	Total	388	141,946		98,149	69.15%	22,929	22,929	3.68
23.	Observation Bed Days				7,763				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				8,548		3,034	3,034	3.24
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				747				
6.	Coronary Care Unit				545				
7.	Other								
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				2,077				
22.	Total				11,917	12.14%	3,034	3,034	3.24

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-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	47,472,943	115,227,425	0.411993	3,326,032		1,370,302	
2.	Recovery Room	7,298,412	20,830,881	0.350365	391,138		137,041	
3.	Delivery and Labor Room	14,745,966	34,914,670	0.422343	3,621,171		1,529,376	
4.	Anesthesiology	1,590,286	23,286,113	0.068293	528,953		36,124	
5.	Radiology - Diagnostic	17,123,088	82,541,118	0.207449	1,996,367		414,144	
6.	Radiology - Therapeutic	10,406,433	34,291,458	0.303470	58,807		17,846	
7.	Nuclear Medicine	2,196,864	20,586,123	0.106716	212,081		22,632	
8.	Laboratory	46,896,561	385,489,427	0.121655	6,083,269		740,060	
9.	Blood							
10.	Blood - Administration	5,361,265	17,120,662	0.313146	301,127		94,297	
11.	Intravenous Therapy							
12.	Respiratory Therapy	5,144,084	28,525,714	0.180331	2,307,895		416,185	
13.	Physical Therapy	6,507,180	16,541,140	0.393394	122,508		48,194	
14.	Occupational Therapy	1,305,868	5,050,664	0.258554	67,896		17,555	
15.	Speech Pathology	1,236,327	4,903,148	0.252150	194,990		49,167	
16.	EKG	18,014,134	149,570,496	0.120439	1,085,338		130,717	
17.	EEG	2,938,410	15,669,384	0.187526	293,876		55,109	
18.	Med. / Surg. Supplies	31,757,541	275,766,160	0.115161	6,713,320		773,113	
19.	Drugs Charged to Patients	47,987,279	288,985,083	0.166055	9,575,216		1,590,012	
20.	Renal Dialysis							
21.	Ambulance							
22.	MRI	3,323,465	55,990,979	0.059357	875,900		51,991	
23.	Cat Scan	3,953,518	117,609,946	0.033616	2,070,648		69,607	
24.	Acute Dialysis	56,475	357,540	0.157954	382,894		60,480	
25.	Patient Treatment Ctr.	3,052,955	5,187,268	0.588548				
26.	Rehab - Bloomingdale	932,116	3,562,534	0.261644				
27.	Pain Management	1,017,409	3,746,269	0.271579				
28.	Mental Health OP	3,945,167	12,893,872	0.305972	123,563		37,807	
29.	Cardiac Rehab	852,085	2,143,546	0.397512				
30.	Women's Clinic							
31.	Implant Dev. Charged	40,136,071	172,886,892	0.232152	4,208,801		977,082	
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	19,675,743	57,713,115	0.340923	135,013		46,029	
44.	Emergency	22,534,732	110,370,429	0.204174	197,415		40,307	
45.	Observation	9,502,921	24,790,816	0.383324	629,556		241,324	
46.	Total				45,503,774		8,966,501	

* 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-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	93,780,283	8,244,599		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	76,697	5,179		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,222.74	1,591.93		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	8,548			
3.	Program general inpatient routine cost (Line 1c X Line 2)	10,451,982			
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)	10,451,982			

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	12,135,803	5,891	2,060.06	747	1,538,865
9.	Coronary Care Unit	8,694,957	4,300	2,022.08	545	1,102,034
10.	Other					
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	11,568,823	13,845	835.60	2,077	1,735,541
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,966,501
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					23,794,923

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

Preliminary-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
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 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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	170,000	115,227,425	0.001475	3,326,032		4,906	
2.	Recovery Room							
3.	Delivery and Labor Room	1,243,284	34,914,670	0.035609	3,621,171		128,946	
4.	Anesthesiology	126,000	23,286,113	0.005411	528,953		2,862	
5.	Radiology - Diagnostic	161,114	82,541,118	0.001952	1,996,367		3,897	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	211,480	20,586,123	0.010273	212,081		2,179	
8.	Laboratory	1,039,670	385,489,427	0.002697	6,083,269		16,407	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	3,861	28,525,714	0.000135	2,307,895		312	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	5,924,417	149,570,496	0.039610	1,085,338		42,990	
17.	EEG	17,528	15,669,384	0.001119	293,876		329	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	MRI							
23.	Cat Scan	120,915	117,609,946	0.001028	2,070,648		2,129	
24.	Acute Dialysis	117,038	357,540	0.327342	382,894		125,337	
25.	Patient Treatment Ctr.	34,692	5,187,268	0.006688				
26.	Rehab - Bloomingle							
27.	Pain Management							
28.	Mental Health OP	32,539	12,893,872	0.002524	123,563		312	
29.	Cardiac Rehab	5,976	2,143,546	0.002788				
30.	Women's Clinic							
31.	Implant Dev. Charged							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Cost Centers								
43.	Clinic	3,660,591	57,713,115	0.063427	135,013		8,563	
44.	Emergency	902,988	110,370,429	0.008181	197,415		1,615	
45.	Observation							
46.	Ancillary Total						340,784	

* 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-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	5,091,403	76,697	66.38	8,548		567,416	
48.	Psych	242,220	5,179	46.77				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit	84,703	4,300	19.70	545		10,737	
53.	Other							
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)						578,153	
68.	Ancillary Total (from line 46)						340,784	
69.	Total (Lines 67-68)						918,937	

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

Preliminary-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	23,794,923	
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)	918,937	
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	24,713,860	
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	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	45,503,774	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	19,758,552	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	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)	65,262,326	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		40,548,466
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-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	24,713,860	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	24,713,860	
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)	24,713,860	

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	40,548,466
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-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
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.	MRI							
23.	Cat Scan							
24.	Acute Dialysis							
25.	Patient Treatment Ctr.							
26.	Rehab - Bloomingtondale							
27.	Pain Management							
28.	Mental Health OP							
29.	Cardiac Rehab							
30.	Women's Clinic							
31.	Implant Dev. Charged							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary 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 G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary-Revised

Medicare Provider Number:	14-0242	Medicaid Provider Number:	23008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2011 To: 06/30/2012

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
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
Reconciliation of Patient Days and Revenue**

Preliminary-Revised

Medicare Provider Number: 14-0242	Medicaid Provider Number: 23008
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2011 To: 06/30/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,840		9,840
Newborn Days	2,077		2,077
Total Inpatient Revenue	125,682,116	(60,419,790)	65,262,326
Ancillary Revenue	105,923,564	(60,419,790)	45,503,774
Routine Revenue	19,758,552		19,758,552
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- BHF Page 2 - Nursery beds and Bed Days Available were adjusted to agree with the prior year cost report.
 - BHF Page 3 -Reclassified Blood to Blood Administration cost center
 - BHF Page 3 - Total costs agree with as filed W/S C Pt. 1, column 1 with the exception of O.R., Rad.Ther.,EKG, and E.R.
 - BHF Page 3 - Total costs for O.R., Rad. Ther., EKG and E.R. were adjusted to agree with W/S C Pt. 1, column 1
 - BHF Page 3 - Total charges agree with as filed W/S C Part 1, column 8
 - BHF Page 4 - Total Adult and Peds cost was adjusted to agree with as filed W/S C Part 1, column 1
 - BHF Page 6 - Total professional component for Mental Health OP was reclassified from Pain Management to agree with as filed W/S A-8-2
- Revision was made 02/07/2013 after adjustment by hospital. Initial Med Supplies were \$67,133,110. Should be \$6,713,320.