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:** 07/01/2011	**To:** 06/30/2012

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 07/01/2011 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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: 07/01/2011 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	302	109,882		72,052	65.57%		19,167	5.12
2.	Psych	45	16,470		13,783	83.69%		1,148	12.01
3.	Rehab	17	6,222		3,769	60.58%		320	11.78
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,052		6,621	82.23%			
6.	Coronary Care Unit	22	7,044		4,527	64.27%			
7.	Pediatric ICU	17	7,298		2,762	37.85%			
8.	Neonatal ICU	58	21,228		12,121	57.10%			
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				4,238				
22.	**Total**	**483**	**176,196**		**119,873**	**68.03%**		**20,635**	**5.60**
23.	Observation Bed Days				6,039				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				21,487			6,916	4.56
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,125				
6.	Coronary Care Unit				993				
7.	Pediatric ICU				1,772				
8.	Neonatal ICU				6,137				
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				2,342				
22.	**Total**				**33,856**	**28.24%**		**6,916**	**4.56**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	135,162	505,568

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: 07/01/2011 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	37,685,931	97,123,532	0.388021	10,975,235	16,626,825	4,258,622	6,451,557
2.	Recovery Room	3,813,823	7,527,967	0.506621	701,096	1,701,774	355,190	862,154
3.	Delivery and Labor Room	14,251,923	27,433,951	0.519499	12,653,213	2,222,668	6,573,332	1,154,674
4.	Anesthesiology	3,459,956	42,893,851	0.080663	7,738,973	6,294,191	624,249	507,708
5.	Radiology - Diagnostic	6,352,976	25,363,749	0.250475	2,196,555	4,251,683	550,182	1,064,940
6.	Radiology - Therapeutic	10,159,882	30,143,874	0.337046	278,043	3,132,659	93,713	1,055,850
7.	Nuclear Medicine	1,634,800	5,457,462	0.299553	326,707	913,566	97,866	273,661
8.	Laboratory	37,266,743	236,413,809	0.157634	28,578,392	36,001,564	4,504,926	5,675,071
9.	Blood							
10.	Blood - Administration	7,839,460	27,241,251	0.287779	5,820,561	1,872,679	1,675,035	538,918
11.	Intravenous Therapy	1,179,993	504,960	2.336805		2,977		6,957
12.	Respiratory Therapy	5,591,544	25,650,065	0.217993	6,333,603	1,172,562	1,380,681	255,610
13.	Physical Therapy	6,429,751	13,919,181	0.461935	869,625	2,748,120	401,710	1,269,453
14.	Occupational Therapy	2,620,974	5,414,395	0.484075	345,127	478,912	167,067	231,829
15.	Speech Pathology	780,192	1,368,227	0.570221	299,651	287,261	170,867	163,802
16.	EKG	526,067	4,327,531	0.121563	590,300	475,705	71,759	57,828
17.	EEG	829,716	3,894,758	0.213034	738,392	174,998	157,303	37,281
18.	Med. / Surg. Supplies	64,228,511	189,883,568	0.338252	32,086,436	12,508,755	10,853,301	4,231,111
19.	Drugs Charged to Patients	65,842,961	228,597,888	0.288030	53,761,838	11,216,283	15,485,022	3,230,626
20.	Renal Dialysis	9,432,541	33,430,784	0.282151	1,783,954	3,518,507	503,344	992,750
21.	Ambulance							
22.	Ultrasound	2,065,666	9,865,402	0.209385	1,159,877	1,509,697	242,861	316,108
23.	Radiology Angiography	7,029,642	56,897,173	0.123550	5,884,655	3,519,439	727,049	434,827
24.	Radiology W. Harrison	2,056,582	10,520,129	0.195490	3,445	2,066,658	673	404,011
25.	CT Scan	4,438,264	49,452,001	0.089749	5,324,220	6,397,257	477,843	574,147
26.	MRI	3,226,561	32,855,150	0.098206	2,821,393	5,832,119	277,078	572,749
27.	Cardiac Catheterization	3,025,128	11,620,229	0.260333	1,172,213	1,392,714	305,166	362,569
28.	Lab Issue Typing	2,003,936	4,552,391	0.440194	204,195	408,611	89,885	179,868
29.	Lab Outreach	14,827,618	127,540,744	0.116258				
30.	Gastroenterology	4,227,024	21,247,603	0.198941	1,385,090	2,932,730	275,551	583,440
31.	Bone Marrow Transplant	1,240,925	539,564	2.299866	145,800	20,179	335,320	46,409
32.	Cardiac Services	4,837,755	20,921,588	0.231233	2,578,792	1,954,963	596,302	452,052
33.	Kidney Acquisition	6,855,340	11,221,593	0.610906	1,943,898		1,187,539	
34.	Liver Acquisition	2,608,290	4,124,564	0.632380	1,061,679		671,385	
35.	Pancreas Acquisition	1,155,051	1,983,440	0.582347	198,344		115,505	
36.	Islet Acquisition	222,792	78,401	2.841698				
37.	Other Organ Acquisition	210,651						
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	71,198,298	107,729,746	0.660897	129,533	34,454,745	85,608	22,771,038
44.	Emergency	16,097,659	63,583,041	0.253175	6,126,959	15,175,680	1,551,193	3,842,103
45.	Observation	8,464,746	14,209,732	0.595701	887,520	3,917,044	528,697	2,333,387
46.	**Total**				**197,105,314**	**185,183,525**	**55,391,824**	**60,934,488**

* 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:	07/01/2011	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)	109,458,870	16,066,796	4,437,640	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	78,091	13,783	3,769	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,401.68	1,165.70	1,177.41	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	21,487			
3.	Program general inpatient routine cost (Line 1c X Line 2)	30,117,898			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	30,117,898			

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	16,613,164	6,621	2,509.16	1,125	2,822,805
9.	Coronary Care Unit	13,630,821	4,527	3,011.01	993	2,989,933
10.	Pediatric ICU	8,116,012	2,762	2,938.45	1,772	5,206,933
11.	Neonatal ICU	22,544,487	12,121	1,859.95	6,137	11,414,513
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,280,410	4,238	774.05	2,342	1,812,825
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					55,391,824
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**109,756,731**

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: 07/01/2011 To: 06/30/2012

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: 07/01/2011 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							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Ultrasound							
23.	Radiology Angiography							
24.	Radiology W. Harrison							
25.	CT Scan							
26.	MRI							
27.	Cardiac Catheterization							
28.	Lab 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 Organ Acquisition							
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: 07/01/2011 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							
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: 07/01/2011 To: 06/30/2012

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		60,934,488
2.	Inpatient Operating Services (BHF Page 4, Line 25)	109,756,731	
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)	10,574,700	6,775,457
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**120,331,431**	**67,709,945**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	64.00%	36.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	197,105,314	185,183,525
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	38,086,112	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,437,378	
	F. Coronary Care Unit	3,778,767	
	G. Pediatric ICU	5,820,895	
	H. Neonatal ICU	19,339,122	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,097,850	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	270,665,438	185,183,525
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		267,807,587
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: 07/01/2011 To: 06/30/2012

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)	120,331,431	67,709,945
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	120,331,431	67,709,945
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)**	**120,331,431**	**67,709,945**

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: 07/01/2011 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)	267,807,587
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:**
14-0150	**3098**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**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

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	6,863,504	97,123,532	0.070668	10,975,235	16,626,825	775,598	1,174,984
2.	Recovery Room	90,012	7,527,967	0.011957	701,096	1,701,774	8,383	20,348
3.	Delivery and Labor Room	1,112,647	27,433,951	0.040557	12,653,213	2,222,668	513,176	90,145
4.	Anesthesiology	1,771,659	42,893,851	0.041303	7,738,973	6,294,191	319,643	259,969
5.	Radiology - Diagnostic	305,507	25,363,749	0.012045	2,196,555	4,251,683	26,458	51,212
6.	Radiology - Therapeutic	1,971,805	30,143,874	0.065413	278,043	3,132,659	18,188	204,917
7.	Nuclear Medicine	246,525	5,457,462	0.045172	326,707	913,566	14,758	41,268
8.	Laboratory	8,101,970	236,413,809	0.034270	28,578,392	36,001,564	979,381	1,233,774
9.	Blood							
10.	Blood - Administration	1,392,480	27,241,251	0.051117	5,820,561	1,872,679	297,530	95,726
11.	Intravenous Therapy	470,776	504,960	0.932304		2,977		2,775
12.	Respiratory Therapy	1,459,435	25,650,065	0.056898	6,333,603	1,172,562	360,369	66,716
13.	Physical Therapy	408,418	13,919,181	0.029342	869,625	2,748,120	25,517	80,635
14.	Occupational Therapy	192,333	5,414,395	0.035523	345,127	478,912	12,260	17,012
15.	Speech Pathology	139,553	1,368,227	0.101996	299,651	287,261	30,563	29,299
16.	EKG	412,523	4,327,531	0.095325	590,300	475,705	56,270	45,347
17.	EEG	46,570	3,894,758	0.011957	738,392	174,998	8,829	2,092
18.	Med. / Surg. Supplies	3,797,150	189,883,568	0.019997	32,086,436	12,508,755	641,632	250,138
19.	Drugs Charged to Patients	9,012,374	228,597,888	0.039425	53,761,838	11,216,283	2,119,560	442,202
20.	Renal Dialysis	1,494,716	33,430,784	0.044711	1,783,954	3,518,507	79,762	157,316
21.	Ambulance							
22.	Ultrasound	280,752	9,865,402	0.028458	1,159,877	1,509,697	33,008	42,963
23.	Radiology Angiography	2,004,422	56,897,173	0.035229	5,884,655	3,519,439	207,311	123,986
24.	Radiology W. Harrison	133,652	10,520,129	0.012704	3,445	2,066,658	44	26,255
25.	CT Scan	1,402,025	49,452,001	0.028351	5,324,220	6,397,257	150,947	181,369
26.	MRI	1,151,807	32,855,150	0.035057	2,821,393	5,832,119	98,910	204,457
27.	Cardiac Catheterization	1,742,966	11,620,229	0.149994	1,172,213	1,392,714	175,825	208,899
28.	Lab Issue Typing	54,433	4,552,391	0.011957	204,195	408,611	2,442	4,886
29.	Lab Outreach	1,525,005	127,540,744	0.011957				
30.	Gastroenterology	254,058	21,247,603	0.011957	1,385,090	2,932,730	16,562	35,067
31.	Bone Marrow Transplant	6,452	539,564	0.011958	145,800	20,179	1,743	241
32.	Cardiac Services	250,159	20,921,588	0.011957	2,578,792	1,954,963	30,835	23,375
33.	Kidney Acquisition	345,365	11,221,593	0.030777	1,943,898		59,827	
34.	Liver Acquisition	242,906	4,124,564	0.058893	1,061,679		62,525	
35.	Pancreas Acquisition	23,716	1,983,440	0.011957	198,344		2,372	
36.	Islet Acquisition							
37.	Other Organ Acquisition	43,997		#DIV/0!				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,661,201	107,729,746	0.033985	129,533	34,454,745	4,402	1,170,945
44.	Emergency	2,041,041	63,583,041	0.032100	6,126,959	15,175,680	196,675	487,139
45.	Observation							
46.	**Ancillary Total**						**7,331,305**	**6,775,457**

* 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: 07/01/2011 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	5,972,457	78,091	76.48	21,487		1,643,326	
48.	Psych	840,591	13,783	60.99				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	955,243	6,621	144.27	1,125		162,304	
52.	Coronary Care Unit	797,136	4,527	176.08	993		174,847	
53.	Pediatric ICU	496,359	2,762	179.71	1,772		318,446	
54.	Neonatal ICU	1,710,346	12,121	141.11	6,137		865,992	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	142,030	4,238	33.51	2,342		78,480	
67.	**Routine Total (lines 47-66)**						**3,243,395**	
68.	**Ancillary Total (from line 46)**						**7,331,305**	**6,775,457**
69.	**Total (Lines 67-68)**						**10,574,700**	**6,775,457**

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: 07/01/2011 To: 06/30/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	31,514		31,514
Newborn Days	2,342		2,342
Total Inpatient Revenue	270,665,438		270,665,438
Ancillary Revenue	197,105,314		197,105,314
Routine Revenue	73,560,124		73,560,124
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	135,162		135,162
Total Outpatient Revenue	185,183,525		185,183,525
Outpatient Received and Receivable			

Notes:

Reclassified Blood charges as Blood Admin.
BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1, as directed in the instructions. Not sure where filed numbers came from.
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.

Adults & Peds charges on BHF Page 7 includes Psych and Rehab charges from filed cost report.