Hospital Statement of Cost

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

General Information

REVISED-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: 09/01/2011	To: 08/31/2012

Type of Control

Voluntary Nonprofit

- [ ] Church
- [XXXX XXXX] Corporation
- [ ] Other (Specify) ____

Proprietary

- [ ] Individual
- [ ] Partnership
- [ ] Corporation

Government (Non-Federal)

- [ ] State
- [ ] City
- [ ] County
- [ ] Township
- [ ] Hospital District
- [ ] Other (Specify) ____

Type of Hospital

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

Health Care Program

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

- [ ] Medicaid Hospital
- [XXXX XXXX] Medicaid Sub I Psych
- [ ] Medicaid Sub II Rehab
- [ ] Medicaid Sub III Other
- [ ] DHS - Office of Rehabilitation Services
- [ ] 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 Hosp 3122 for the cost report beginning 09/01/2011 and ending 08/31/2012 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): ____

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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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	678	238,117		179,725	75.48%		47,818	4.83
2.	Psych	29	10,585		9,792	92.51%		1,120	8.74
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	106	34,750		28,488	81.98%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,390		22,664	72.20%			
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		26,760	64.31%			
22.	**Total**	**1,013**	**356,452**		**267,429**	**75.03%**		**48,938**	**4.92**
23.	Observation Bed Days				10,347				

Line No.	**Part II-Program**	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				2,212			266	8.32
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Special Care Nursery								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**2,212**	**0.83%**		**266**	**8.32**

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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	Period Covered by Statement:
Medicaid-Psychiatric	From: 09/01/2011 To: 08/31/2012

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	83,593,812	613,530,931	0.136250				
2.	Recovery Room	15,150,409	51,586,066	0.293692	108,811		31,957	
3.	Delivery and Labor Room	32,082,408	148,979,517	0.215348				
4.	Anesthesiology	5,308,445	49,386,326	0.107488	7,600		817	
5.	Radiology - Diagnostic	50,669,657	282,439,837	0.179400	26,030		4,670	
6.	Radiology - Therapeutic	19,316,187	150,602,580	0.128259				
7.	Nuclear Medicine	9,592,163	65,224,856	0.147063				
8.	Laboratory	72,024,003	696,033,162	0.103478	529,479		54,789	
9.	Blood							
10.	Blood - Administration	19,536,427	81,606,065	0.239399	779		186	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,906,776	148,229,591	0.107312	27,357		2,936	
13.	Physical Therapy	4,383,766	12,502,924	0.350619	7,988		2,801	
14.	Occupational Therapy	1,805,392	6,946,987	0.259881	2,658		691	
15.	Speech Pathology							
16.	EKG	4,163,882	28,806,804	0.144545	46,765		6,760	
17.	EEG	5,814,595	33,245,357	0.174899	22,824		3,992	
18.	Med. / Surg. Supplies	58,687,389	168,696,443	0.347888	18,814		6,545	
19.	Drugs Charged to Patients	66,989,086	280,558,994	0.238770	314,411		75,072	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	7,673,210	49,871,037	0.153861				
23.	Cardiology Graphics	8,442,999	83,855,474	0.100685	9,150		921	
24.	Pulmonary Funcation Testing	1,451,093	11,942,155	0.121510				
25.	MRI	23,192,130	182,553,083	0.127043	61,342		7,793	
26.	Vascular Lab & Cell Therapy	3,696,880	28,169,365	0.131238	8,457		1,110	
27.	CT & EPS	20,460,973	271,111,357	0.075471	61,700		4,657	
28.	Cast Room							
29.	GI Lab	15,216,986	77,373,149	0.196670	2,200		433	
30.	Transplant Clinic	2,978,904	5,393,048	0.552360				
31.	Transplant Acq (Liver/Kidney/Heart/Pa	22,649,196	37,663,600	0.601355				
32.	OB & Psych Clinic	14,566,701	14,096,185	1.033379	119,433		123,420	
33.	Blood Flow Lab	8,246,255	36,777,825	0.224218	925		207	
34.	Implantable Devices	64,602,115	158,050,829	0.408743				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	5,170,531	4,080,846	1.267024				
44.	Emergency	29,116,636	166,853,183	0.174505	465,765		81,278	
45.	Observation	16,329,950	37,294,752	0.437862				
46.	**Total**				**1,842,488**		**411,035**	

* 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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	Period Covered by Statement:
Medicaid-Psychiatric	From: 09/01/2011 To: 08/31/2012

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)	231,346,634	10,364,012		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	190,072	9,792		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,217.15	1,058.42		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		2,212		
3.	Program general inpatient routine cost (Line 1c X Line 2)		2,341,225		
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)		2,341,225		

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	58,624,158	28,488	2,057.85		
9.	Coronary Care Unit					
10.	Special Care Nursery	29,029,126	22,664	1,280.85		
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	5,050,768	26,760	188.74		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					411,035
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,752,260**

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

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122		
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011	To: 08/31/2012	

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.	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 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	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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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.	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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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.	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

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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)	2,752,260	
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)	372,794	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**3,125,054**	
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)	1,842,488	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	4,839,912	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Special Care Nursery		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	6,682,400	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,557,346
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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122	
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011	To: 08/31/2012

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)	3,125,054	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,125,054	
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)**	**3,125,054**	

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

REVISED-PRELIMINARY

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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)	3,557,346
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	**Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)**					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
		(1)	(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	**Total (Sum of Lines 1 - 3)**					

Hospital Statement of Cost

Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:		
14-0281	3122		
Program:	Period Covered by Statement:		
Medicaid-Psychiatric	From: 09/01/2011	To:	08/31/2012

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)

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	**Period Covered by Statement:**
Medicaid-Psychiatric	From: 09/01/2011 To: 08/31/2012

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	12,810,589	613,530,931	0.020880				
2.	Recovery Room	593,563	51,586,066	0.011506	108,811		1,252	
3.	Delivery and Labor Room	2,114,928	148,979,517	0.014196				
4.	Anesthesiology	86,441	49,386,326	0.001750	7,600		13	
5.	Radiology - Diagnostic	3,884,092	282,439,837	0.013752	26,030		358	
6.	Radiology - Therapeutic	1,238,991	150,602,580	0.008227				
7.	Nuclear Medicine	167,120	65,224,856	0.002562				
8.	Laboratory	3,163,749	696,033,162	0.004545	529,479		2,406	
9.	Blood							
10.	Blood - Administration	242,036	81,606,065	0.002966	779		2	
11.	Intravenous Therapy							
12.	Respiratory Therapy	167,120	148,229,591	0.001127	27,357		31	
13.	Physical Therapy	17,288	12,502,924	0.001383	7,988		11	
14.	Occupational Therapy	17,288	6,946,987	0.002489	2,658		7	
15.	Speech Pathology							
16.	EKG							
17.	EEG	138,306	33,245,357	0.004160	22,824		95	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	334,239	49,871,037	0.006702				
23.	Cardiology Graphics	512,884	83,855,474	0.006116	9,150		56	
24.	Pulmonary Funcation Testing	190,170	11,942,155	0.015924				
25.	MRI							
26.	Vascular Lab & Cell Therapy							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab	322,714	77,373,149	0.004171	2,200		9	
30.	Transplant Clinic	288,137	5,393,048	0.053427				
31.	Transplant Acq (Liver/Kidney/Heart/P							
32.	OB & Psych Clinic	1,279,329	14,096,185	0.090757	119,433		10,839	
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	898,989	4,080,846	0.220295				
44.	Emergency	1,763,401	166,853,183	0.010569	465,765		4,923	
45.	Observation							
46.	**Ancillary Total**						**20,002**	

* 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)

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program: Medicaid-Psychiatric	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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	13,300,425	190,072	69.98				
48.	Psych	1,561,705	9,792	159.49	2,212		352,792	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,641,731	28,488	198.04				
52.	Coronary Care Unit							
53.	Special Care Nursery	311,189	22,664	13.73				
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)**						**352,792**	
68.	**Ancillary Total (from line 46)**						**20,002**	
69.	**Total (Lines 67-68)**						**372,794**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

REVISED-PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0281	3122
Program:	Period Covered by Statement:
Medicaid-Psychiatric	From: 09/01/2011 To: 08/31/2012

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,212		2,212
Newborn Days			
Total Inpatient Revenue	6,682,400		6,682,400
Ancillary Revenue	1,842,488		1,842,488
Routine Revenue	4,839,912		4,839,912
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Data was transferred to the correct cost report form. Filed report was entered on an old form.

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.
Solid Organ Transplant on BHF Page 3 is reclassified to Transplant Clinic to agree with W/S C.

Revised due to revised Medicare report submitted by provider-06/27/2014. DW