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 Chicago Medical Center		**Medicare Provider Number:** 14-0088
Street: 5841 South Maryland Avenue		**Medicaid Provider Number:** 3023
City: Chicago	**State:** Illinois	**Zip:** 60637-1424
Period Covered by Statement:	**From:** 07/01/2013	**To:** 06/30/2014

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX XXXX	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX 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 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 Chicago Medica 3023 for the cost report beginning 07/01/2013 and ending 06/30/2014 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

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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	369	134,685		102,516	76.12%		20,842	6.01
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	60	21,900		17,628	80.49%			
6.	Coronary Care Unit	9	3,285		3,285	100.00%			
7.	Burn ICU	6	2,190		1,785	81.51%			
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,935		1,228	17.71%			
22.	**Total**	**463**	**168,995**		**126,442**	**74.82%**		**20,842**	**6.01**
23.	Observation Bed Days				5,395				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				17,423			3,389	6.12
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,605				
6.	Coronary Care Unit				339				
7.	Burn ICU				383				
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				747				
22.	**Total**				**21,497**	**17.00%**		**3,389**	**6.12**

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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	102,941,028	426,467,258	0.241381	23,112,728		5,578,973	
2.	Recovery Room							
3.	Delivery and Labor Room	10,691,076	19,521,773	0.547649	8,013,190		4,388,415	
4.	Anesthesiology	10,741,459	145,335,618	0.073908	8,708,445		643,624	
5.	Radiology - Diagnostic	46,719,854	188,387,600	0.247999	10,565,040		2,620,119	
6.	Radiology - Therapeutic	14,017,136	108,178,811	0.129574	2,582,506		334,626	
7.	Nuclear Medicine							
8.	Laboratory	59,636,884	505,988,816	0.117862	37,764,889		4,451,045	
9.	Blood							
10.	Blood - Administration	19,555,158	116,127,982	0.168393	12,224,260		2,058,480	
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,226,739	118,828,209	0.170218	10,851,588		1,847,136	
13.	Physical Therapy	10,992,576	39,343,103	0.279403	2,137,752		597,294	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	15,061,174	119,804,958	0.125714	8,513,774		1,070,301	
17.	EEG	5,571,532	24,622,493	0.226278	1,785,906		404,111	
18.	Med. / Surg. Supplies	29,423,770	91,316,952	0.322216	6,046,063		1,948,138	
19.	Drugs Charged to Patients	104,451,550	691,191,732	0.151118	41,921,139		6,335,039	
20.	Renal Dialysis	4,913,616	23,194,303	0.211846	3,127,543		662,557	
21.	Ambulance	1,405,803	11,148	126.103606	95		11,980	
22.	Brace and Plaster Rm	234,686	1,044,096	0.224774	5,145		1,156	
23.	Kidney Acquisition	5,657,277	4,976,725	1.136747	217,444		247,179	
24.	Liver Acquisition	2,231,911	2,748,682	0.811993	142,861		116,002	
25.	Heart Acquisition	2,136,672	3,210,227	0.665583				
26.	Pancreas Acquisition	277,723	690,394	0.402267				
27.	Implants Dev. Charged	45,024,469	166,775,047	0.269971	10,009,954		2,702,397	
28.	Lung Acquisition	1,672,472	2,430,005	0.688259				
29.	Cardiac Rehab	213,324	624,883	0.341382				
30.	CT Scan	8,394,196	210,125,864	0.039948	10,483,433		418,792	
31.	MRI	7,445,064	108,788,677	0.068436	4,184,923		286,399	
32.	Cardiac Cath	1,288,403	61,221,323	0.021045	3,725,317		78,399	
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	123,245,635	314,038,076	0.392454	5,286,753		2,074,807	
44.	Emergency	33,288,480	196,625,549	0.169299				
45.	Observation							
46.	**Total**				**211,410,748**		**38,876,969**	

* 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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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)	145,819,202			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	107,911			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,351.29			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	17,423			
3.	Program general inpatient routine cost (Line 1c X Line 2)	23,543,526			
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)	23,543,526			

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	42,183,139	17,628	2,392.96	2,605	6,233,661
9.	Coronary Care Unit	9,135,898	3,285	2,781.10	339	942,793
10.	Burn ICU	2,696,031	1,785	1,510.38	383	578,476
11.	Nursery Special Care					
12.	Nursery ICU					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	822,956	1,228	670.16	747	500,610
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					38,876,969
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**70,676,035**

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan							
31.	MRI							
32.	Cardiac Cath							
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							
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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)	70,676,035	
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)	8,659,385	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**79,335,420**	
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)	211,410,748	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	54,090,397	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	21,940,207	
	F. Coronary Care Unit	2,978,147	
	G. Burn ICU	3,044,198	
	H. Nursery Special Care		
	I. Nursery ICU		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,953	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	293,466,650	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		214,131,230
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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)	79,335,420	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	79,335,420	
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)**	**79,335,420**	

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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)	214,131,230
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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
14-0088	**3023**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2013 To: 06/30/2014**

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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	10,512,142	426,467,258	0.024649	23,112,728		569,706	
2.	Recovery Room							
3.	Delivery and Labor Room	3,319,296	19,521,773	0.170030	8,013,190		1,362,483	
4.	Anesthesiology	7,024,702	145,335,618	0.048334	8,708,445		420,914	
5.	Radiology - Diagnostic	4,396,666	188,387,600	0.023338	10,565,040		246,567	
6.	Radiology - Therapeutic	1,040,004	108,178,811	0.009614	2,582,506		24,828	
7.	Nuclear Medicine							
8.	Laboratory	5,760,504	505,988,816	0.011385	37,764,889		429,953	
9.	Blood							
10.	Blood - Administration	37,366	116,127,982	0.000322	12,224,260		3,936	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	541,799	119,804,958	0.004522	8,513,774		38,499	
17.	EEG	772,219	24,622,493	0.031362	1,785,906		56,010	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	124,552	23,194,303	0.005370	3,127,543		16,795	
21.	Ambulance							
22.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan	622,757	210,125,864	0.002964	10,483,433		31,073	
31.	MRI	130,779	108,788,677	0.001202	4,184,923		5,030	
32.	Cardiac Cath	660,123	61,221,323	0.010783	3,725,317		40,170	
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	10,094,894	314,038,076	0.032145	5,286,753		169,943	
44.	Emergency	3,051,510	196,625,549	0.015519				
45.	Observation							
46.	**Ancillary Total**						**3,415,907**	

* 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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

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	26,772,083	107,911	248.09	17,423		4,322,472	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,453,738	17,628	252.65	2,605		658,153	
52.	Coronary Care Unit	1,836,575	3,285	559.08	339		189,528	
53.	Burn ICU	341,745	1,785	191.45	383		73,325	
54.	Nursery Special Care							
55.	Nursery ICU							
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)**						**5,243,478**	
68.	**Ancillary Total (from line 46)**						**3,415,907**	
69.	**Total (Lines 67-68)**						**8,659,385**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-0088	3023	
Program:	**Period Covered by Statement:**	
Medicaid Hospital	From: 07/01/2013	To: 06/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	20,750		20,750
Newborn Days	747		747
Total Inpatient Revenue	293,466,650		293,466,650
Ancillary Revenue	211,410,748		211,410,748
Routine Revenue	82,055,902		82,055,902
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Room & Board costs split between Acute and Children's Hospital.
Observation Bed Days were taken from the as filed W/S S-3 and split between Acute and Children's Hospital
BHF Page 3 - total costs agree with W/S C Part 1, column 1

GME costs were adjusted to as filed W/S B Part 1, column 25 and split between Acute and Children's Hospital.

Report was filed by an outdated form.