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 Hospital & Health Sciences		**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:** 07/01/2013	**To:** 06/30/2014

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual	XXXX XXXX	State		Township
	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)

	Medicaid Hospital	XXXX XXXX	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 Hospital , 3098 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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Rehab	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	343	125,195		70,609	56.40%		19,561	4.89
2.	Psych	53	19,345		13,220	68.34%		1,038	12.74
3.	Rehab	18	6,570		4,822	73.39%		397	12.15
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,030		5,659	70.47%			
6.	Coronary Care Unit	19	6,935		4,841	69.81%			
7.	Pediatric ICU	18	6,570		2,591	39.44%			
8.	Neonatal ICU	52	18,980		11,887	62.63%			
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				3,851				
22.	**Total**	**525**	**191,625**		**117,480**	**61.31%**		**20,996**	**5.41**
23.	Observation Bed Days				4,916				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				1,245			105	11.86
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU								
8.	Neonatal ICU								
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**				**1,245**	**1.06%**		**105**	**11.86**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		500,678

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-Rehab	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	38,602,416	131,372,637	0.293839	27,165		7,982	
2.	Recovery Room	6,256,841	10,048,656	0.622655	2,739		1,705	
3.	Delivery and Labor Room	12,068,793	25,209,613	0.478738				
4.	Anesthesiology	3,553,871	53,896,003	0.065939	8,871		585	
5.	Radiology - Diagnostic	6,730,938	26,505,180	0.253948	10,754		2,731	
6.	Radiology - Therapeutic	9,976,388	24,085,606	0.414205	32,062		13,280	
7.	Nuclear Medicine	2,009,202	7,198,511	0.279114				
8.	Laboratory	39,867,989	256,436,418	0.155469	151,375		23,534	
9.	Blood							
10.	Blood - Administration	7,822,797	28,967,086	0.270058	6,745		1,822	
11.	Intravenous Therapy	604,877	1,520,064	0.397929	1,233		491	
12.	Respiratory Therapy	6,322,277	27,221,506	0.232253	45,914		10,664	
13.	Physical Therapy	8,257,348	17,126,728	0.482132	555,881		268,008	
14.	Occupational Therapy	3,341,546	6,344,557	0.526679	472,184		248,689	
15.	Speech Pathology	851,552	1,397,218	0.609463	70,140		42,748	
16.	EKG	524,104	4,152,586	0.126211	3,300		416	
17.	EEG	691,273	5,638,059	0.122608	4,770		585	
18.	Med. / Surg. Supplies	64,357,129	190,516,021	0.337804	250,959		84,775	
19.	Drugs Charged to Patients	67,708,421	245,058,068	0.276295	560,901		154,974	
20.	Renal Dialysis	9,635,154	30,461,514	0.316306	42,360		13,399	
21.	Ambulance							
22.	Ultrasound	2,179,415	10,753,262	0.202675	4,127		836	
23.	Radiology Angiography	5,934,691	49,314,367	0.120344	9,649		1,161	
24.	Radiology W. Harrison	2,593,410	10,755,124	0.241133				
25.	CT Scan	4,544,922	55,495,062	0.081898	32,764		2,683	
26.	MRI	4,539,859	42,163,796	0.107672	20,092		2,163	
27.	Cardiac Catheterization	2,448,788	11,951,607	0.204892				
28.	Lab Tissue Typing	1,918,057	4,441,913	0.431809				
29.	Lab Outreach	12,641,078	123,287,906	0.102533				
30.	Gastroenterology	4,457,791	21,132,218	0.210948				
31.	Bone Marrow Transplant	1,658,207	2,462,971	0.673255				
32.	Cardiac Services	4,451,507	19,435,686	0.229038	8,007		1,834	
33.	Kidney Acquisition	6,467,016	9,136,504	0.707822				
34.	Liver Acquisition	1,358,256	1,666,096	0.815233				
35.	Pancreas Acquisition	1,111,248	1,666,096	0.666977				
36.	Islet & Other Acquisition	590,324	66,934	8.819494				
37.	Telemedicine Program	2,101,995	1,425,049	1.475033				
38.	Sleep Lab W Harrison	1,553,505	3,742,241	0.415127				
39.	Radio Mile Square	364,905	488,615	0.746815				
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	81,433,003	117,507,512	0.693003				
44.	Emergency	17,203,559	74,660,947	0.230422	2,133		491	
45.	Observation	7,727,755	12,368,291	0.624804				
46.	**Total**				**2,324,125**		**885,556**	

* 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-Rehab	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)	118,721,914	15,802,003	6,191,953	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	75,525	13,220	4,822	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,571.96	1,195.31	1,284.10	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,245	
3.	Program general inpatient routine cost (Line 1c X Line 2)			1,598,705	
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)			1,598,705	

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	15,446,539	5,659	2,729.55		
9.	Coronary Care Unit	12,978,358	4,841	2,680.93		
10.	Pediatric ICU	7,786,097	2,591	3,005.05		
11.	Neonatal ICU	24,150,838	11,887	2,031.70		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,617,475	3,851	679.69		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					885,556
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**2,484,261**

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-Rehab	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.	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-Rehab	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.	Ultrasound							
23.	Radiology Angiography							
24.	Radiology W. Harrison							
25.	CT Scan							
26.	MRI							
27.	Cardiac Catheterization							
28.	Lab Tissue Typing							
29.	Lab Outreach							
30.	Gastroenterology							
31.	Bone Marrow Transplant							
32.	Cardiac Services							
33.	Kidney Acquisition							
34.	Liver Acquisition							
35.	Pancreas Acquisition							
36.	Islet & Other Acquisition							
37.	Telemedicine Program							
38.	Sleep Lab W Harrison							
39.	Radio Mile Square							
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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	**Medicaid Provider Number:**
14-0150	**3098**
Program:	**Period Covered by Statement:**
Medicaid-Rehab	**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.	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)**							

Rev. 10 / 11

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-Rehab	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)	2,484,261	
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)	100,851	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,585,112**	
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)	2,324,125	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	2,313,160	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Pediatric ICU		
	H. Neonatal ICU		
	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)**	4,637,285	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,052,173
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-Rehab	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)	2,585,112	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,585,112	
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)**	**2,585,112**	

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-Rehab	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)	2,052,173
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-Rehab	**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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Rehab	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	8,880,815	131,372,637	0.067600	27,165		1,836	
2.	Recovery Room	164,738	10,048,656	0.016394	2,739		45	
3.	Delivery and Labor Room	1,337,937	25,209,613	0.053072				
4.	Anesthesiology	2,369,245	53,896,003	0.043960	8,871		390	
5.	Radiology - Diagnostic	434,526	26,505,180	0.016394	10,754		176	
6.	Radiology - Therapeutic	2,296,107	24,085,606	0.095331	32,062		3,057	
7.	Nuclear Medicine	325,799	7,198,511	0.045259				
8.	Laboratory	10,432,730	256,436,418	0.040683	151,375		6,158	
9.	Blood							
10.	Blood - Administration	1,731,995	28,967,086	0.059792	6,745		403	
11.	Intravenous Therapy	24,920	1,520,064	0.016394	1,233		20	
12.	Respiratory Therapy	1,807,271	27,221,506	0.066391	45,914		3,048	
13.	Physical Therapy	566,483	17,126,728	0.033076	555,881		18,386	
14.	Occupational Therapy	254,658	6,344,557	0.040138	472,184		18,953	
15.	Speech Pathology	168,357	1,397,218	0.120494	70,140		8,451	
16.	EKG	494,040	4,152,586	0.118972	3,300		393	
17.	EEG	92,430	5,638,059	0.016394	4,770		78	
18.	Med. / Surg. Supplies	4,925,869	190,516,021	0.025855	250,959		6,489	
19.	Drugs Charged to Patients	12,251,024	245,058,068	0.049992	560,901		28,041	
20.	Renal Dialysis	1,654,340	30,461,514	0.054309	42,360		2,301	
21.	Ambulance							
22.	Ultrasound	368,492	10,753,262	0.034268	4,127		141	
23.	Radiology Angiography	2,351,276	49,314,367	0.047679	9,649		460	
24.	Radiology W. Harrison	176,320	10,755,124	0.016394				
25.	CT Scan	1,808,463	55,495,062	0.032588	32,764		1,068	
26.	MRI	1,569,132	42,163,796	0.037215	20,092		748	
27.	Cardiac Catheterization	2,086,793	11,951,607	0.174604				
28.	Lab Tissue Typing	72,821	4,441,913	0.016394				
29.	Lab Outreach	2,021,182	123,287,906	0.016394				
30.	Gastroenterology	346,442	21,132,218	0.016394				
31.	Bone Marrow Transplant	40,378	2,462,971	0.016394				
32.	Cardiac Services	318,629	19,435,686	0.016394	8,007		131	
33.	Kidney Acquisition	399,128	9,136,504	0.043685				
34.	Liver Acquisition	255,879	1,666,096	0.153580				
35.	Pancreas Acquisition	27,314	1,666,096	0.016394				
36.	Islet & Other Acquisition	53,044	66,934	0.792482				
37.	Telemedicine Program	23,362	1,425,049	0.016394				
38.	Sleep Lab W Harrison	61,350	3,742,241	0.016394				
39.	Radio Mile Square	8,010	488,615	0.016393				
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	4,601,672	117,507,512	0.039161				
44.	Emergency	2,735,640	74,660,947	0.036641	2,133		78	
45.	Observation							
46.	**Ancillary Total**						**100,851**	

* 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-Rehab	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	7,640,973	75,525	101.17				
48.	Psych	1,081,445	13,220	81.80				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,162,759	5,659	205.47				
52.	Coronary Care Unit	1,024,560	4,841	211.64				
53.	Pediatric ICU	598,354	2,591	230.94				
54.	Neonatal ICU	2,177,762	11,887	183.21				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	176,272	3,851	45.77				
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**						**100,851**	
69.	**Total (Lines 67-68)**						**100,851**	

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-Rehab	**From: 07/01/2013 To: 06/30/2014**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	1,245		1,245
Newborn Days			
Total Inpatient Revenue	4,636,985	300	4,637,285
Ancillary Revenue	2,324,125		2,324,125
Routine Revenue	2,312,860	300	2,313,160
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
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.

BHF Page 3-Filed report did not list all ancillary cost centers but BHF could trace to Medicare report.

The names of the cost centers may be entered rather than listing all of them as "Other".