

Hospital Statement of Cost

BHF Page 1

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 System		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: 07/01/2010	To: 06/30/2011	

Type of Control

Voluntary Nonprofit

☐

Church

☐

Corporation

☐

Other (Specify)

Proprietary

☐

Individual

☐

Partnership

☐

Corporation

Government (Non-Federal)

☐

State

☐

City

☐

County

☐

Township

☐

Hospital District

☐

Other (Specify)

Type of Hospital

☒

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

☒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 07/01/2010 and ending 06/30/2011 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

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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	301	109,865		69,116	62.91%		18,424	5.19
2.	Psych	45	17,845		13,398	75.08%		1,123	11.93
3.	Rehab	17	6,205		3,870	62.37%		344	11.25
4.	Other (Sub)								
5.	Intensive Care Unit	22	8,030		5,802	72.25%			
6.	Coronary Care Unit	19	6,935		5,290	76.28%			
7.	Pediatric ICU	21	7,665		4,174	54.46%			
8.	Neonatal ICU	58	21,170		11,193	52.87%			
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	25	9,125		4,219	46.24%			
22.	Total	508	186,840		117,062	62.65%		19,891	5.67
23.	Observation Bed Days				5,700				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				1,242			82	15.15
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				1,242	1.06%		82	15.15

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		486,828

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0150		3098	
Program:		Period Covered by Statement:	
Medicaid-Rehabilitation		From: 07/01/2010	To: 06/30/2011

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	32,605,099	91,196,511	0.357526	6,855		2,451	
2.	Recovery Room	2,860,155	6,788,299	0.421336				
3.	Delivery and Labor Room	12,653,418	24,278,490	0.521178				
4.	Anesthesiology	2,821,064	41,246,230	0.068396	4,217		288	
5.	Radiology - Diagnostic	7,974,986	20,759,584	0.384159	8,041		3,089	
6.	Radiology - Therapeutic	8,656,915	30,451,300	0.284287	17,043		4,845	
7.	Nuclear Medicine	1,639,016	6,117,881	0.267906	1,741		466	
8.	Laboratory	33,414,266	214,346,287	0.155889	155,757		24,281	
9.	Blood							
10.	Blood - Administration	7,743,144	26,155,118	0.296047	2,218		657	
11.	Intravenous Therapy	13,460,120	31,277,457	0.430346				
12.	Respiratory Therapy	5,056,263	23,912,318	0.211450	50,294		10,635	
13.	Physical Therapy	5,353,167	10,996,499	0.486806	458,117		223,014	
14.	Occupational Therapy	2,279,676	4,752,822	0.479647	457,621		219,497	
15.	Speech Pathology	734,055	1,395,842	0.525887	121,537		63,915	
16.	EKG	446,192	4,081,220	0.109328	2,277		249	
17.	EEG	730,993	4,282,322	0.170700	4,734		808	
18.	Med. / Surg. Supplies	56,142,474	168,682,026	0.332830	176,186		58,640	
19.	Drugs Charged to Patients	45,314,601	157,559,663	0.287603	468,108		134,629	
20.	Renal Dialysis	8,752,066	29,063,348	0.301138	18,846		5,675	
21.	Ambulance							
22.	Ultrasound	1,588,031	9,054,655	0.175383	3,618		635	
23.	Radio Angiography	6,098,343	55,242,540	0.110392	13,375		1,476	
24.	Radio W. Harrison	1,129,661	5,351,492	0.211093				
25.	CT Scan	3,954,648	48,638,298	0.081307	19,234		1,564	
26.	MRI	2,378,243	32,285,969	0.073662	10,242		754	
27.	Cardiac Catheterization	2,595,150	10,382,415	0.249956				
28.	Lab Issue Typing	841,298	2,028,603	0.414718				
29.	Lab Outreach	15,372,489	122,154,732	0.125844				
30.	Gastroenterology	3,474,159	18,969,759	0.183142	3,329		610	
31.	Bone Marrow Transplant	1,076,690	580,229	1.855629				
32.	Cardiac Services	4,069,717	18,190,866	0.223723	10,683		2,390	
33.	Kidney Acquisition	7,089,114	10,587,327	0.669585				
34.	Liver Acquisition	2,579,622	4,254,246	0.606364				
35.	Pancreas Acquisition	832,989	1,255,709	0.663361				
36.	Islet Acquisition	316,585	53,901	5.873453				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	65,510,378	101,974,856	0.642417				
44.	Emergency	15,074,559	54,802,524	0.275071				
45.	Observation	7,350,492	12,890,987	0.570204				
46.	Total				2,014,073		760,568	

* 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

BHF Page 4

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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)	96,479,645	14,795,029	3,659,095	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,816	13,398	3,870	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,289.56	1,104.27	945.50	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			1,242	
3.	Program general inpatient routine cost (Line 1c X Line 2)			1,174,311	
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)			1,174,311	

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	13,755,705	5,802	2,370.86		
9.	Coronary Care Unit	13,111,048	5,290	2,478.46		
10.	Pediatric ICU	9,766,453	4,174	2,339.83		
11.	Neonatal ICU	19,596,855	11,193	1,750.81		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,483,333	4,219	588.61		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					760,568
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,934,879

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

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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.	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 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)	
		(1)	(2)	(3)	(4)	Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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.	Radio Angiography							
24.	Radio 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							
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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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**

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		1,934,879	
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)		84,272	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		2,019,151	
8. Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)		100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		2,014,073	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics			
B. Psych			
C. Rehab		1,933,328	
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)		3,947,401	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			1,928,250
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

BHF Page 8

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	2,019,151	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,019,151	
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)	2,019,151	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	Balance Due Provider / (State Agency) * (Line 6 Minus Line 8)		

* Line 9 DOES NOT APPLY to the Medicaid program.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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)	1,928,250
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)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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-Rehabilitation		From: 07/01/2010	To: 06/30/2011

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	6,352,185	91,196,511	0.069654	6,855		477	
2.	Recovery Room	80,740	6,788,299	0.011894				
3.	Delivery and Labor Room	1,012,794	24,278,490	0.041716				
4.	Anesthesiology	1,653,906	41,246,230	0.040098	4,217		169	
5.	Radiology - Diagnostic	246,914	20,759,584	0.011894	8,041		96	
6.	Radiology - Therapeutic	1,850,916	30,451,300	0.060783	17,043		1,036	
7.	Nuclear Medicine	235,469	6,117,881	0.038489	1,741		67	
8.	Laboratory	7,426,480	214,346,287	0.034647	155,757		5,397	
9.	Blood							
10.	Blood - Administration	1,295,439	26,155,118	0.049529	2,218		110	
11.	Intravenous Therapy	372,014	31,277,457	0.011894				
12.	Respiratory Therapy	1,350,114	23,912,318	0.056461	50,294		2,840	
13.	Physical Therapy	354,508	10,996,499	0.032238	458,117		14,769	
14.	Occupational Therapy	174,489	4,752,822	0.036713	457,621		16,801	
15.	Speech Pathology	130,494	1,395,842	0.093488	121,537		11,362	
16.	EKG	382,082	4,081,220	0.093620	2,277		213	
17.	EEG	50,934	4,282,322	0.011894	4,734		56	
18.	Med. / Surg. Supplies	3,417,748	168,682,026	0.020261	176,186		3,570	
19.	Drugs Charged to Patients	8,321,103	157,559,663	0.052812	468,108		24,722	
20.	Renal Dialysis	1,569,633	29,063,348	0.054007	18,846		1,018	
21.	Ambulance							
22.	Ultrasound	258,196	9,054,655	0.028515	3,618		103	
23.	Radio Angiography	1,865,121	55,242,540	0.033762	13,375		452	
24.	Radio W. Harrison	63,651	5,351,492	0.011894				
25.	CT Scan	1,282,192	48,638,298	0.026362	19,234		507	
26.	MRI	1,071,427	32,285,969	0.033186	10,242		340	
27.	Cardiac Catheterization	1,604,081	10,382,415	0.154500				
28.	Lab Issue Typing	24,128	2,028,603	0.011894				
29.	Lab Outreach	1,452,908	122,154,732	0.011894				
30.	Gastroenterology	225,626	18,969,759	0.011894	3,329		40	
31.	Bone Marrow Transplant	6,901	580,229	0.011894				
32.	Cardiac Services	216,362	18,190,866	0.011894	10,683		127	
33.	Kidney Acquisition	321,169	10,587,327	0.030335				
34.	Liver Acquisition	229,573	4,254,246	0.053963				
35.	Pancreas Acquisition	14,935	1,255,709	0.011894				
36.	Islet Acquisition	641	53,901	0.011892				
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Ancillary Centers								
43.	Clinic	3,307,683	101,974,856	0.032436				
44.	Emergency	1,835,482	54,802,524	0.033493				
45.	Observation							
46.	Ancillary Total						84,272	

* 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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehabilitation	Period Covered by Statement:	From: 07/01/2010 To: 06/30/2011

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	5,478,545	74,816	73.23				
48.	Psych	772,517	13,398	57.66				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	857,153	5,802	147.73				
52.	Coronary Care Unit	770,987	5,290	145.74				
53.	Pediatric ICU	519,880	4,174	124.55				
54.	Neonatal ICU	1,557,724	11,193	139.17				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	132,664	4,219	31.44				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						84,272	
69.	Total (Lines 67-68)						84,272	

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehabilitation	Period Covered by Statement: From: 07/01/2010 To: 06/30/2011

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,242		1,242
Newborn Days			
Total Inpatient Revenue	3,947,401		3,947,401
Ancillary Revenue	2,014,073		2,014,073
Routine Revenue	1,933,328		1,933,328
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Nursery Beds and Days Available came from prior year Medicaid report.

Reclassified Blood charges as Blood Admin.

BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1.

Clinic costs and charges include Medicare lines 93.01, 93.02, and 93.03.

GME Costs on BHF Supplement No. 2 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.