

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

Type of Hospital

☐ XXXX General Short-Term XXXX	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify) _____

Health Care Program

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

☐ XXXX Medicaid Hospital 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)) Northwestern Memorial Hospi 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):

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:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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				8,442				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				24,798			6,112	5.33
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,179				
6.	Coronary Care Unit								
7.	Special Care Nursery				5,578				
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				4,753				
22.	Total				37,308	13.95%		6,112	5.33

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:		Medicaid Provider Number:	
14-0281		3122	
Program:		Period Covered by Statement:	
Medicaid-Hospital		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	86,161,310	613,530,931	0.140435	26,201,232		3,679,570	
2.	Recovery Room	15,614,874	51,586,066	0.302696	1,485,027		449,512	
3.	Delivery and Labor Room	33,065,790	148,979,517	0.221949	26,217,160		5,818,872	
4.	Anesthesiology	5,471,075	49,386,326	0.110781	2,151,246		238,317	
5.	Radiology - Diagnostic	52,222,429	282,439,837	0.184898	13,006,578		2,404,890	
6.	Radiology - Therapeutic	19,908,304	150,602,580	0.132191	1,053,000		139,197	
7.	Nuclear Medicine	9,885,977	65,224,856	0.151568	814,559		123,461	
8.	Laboratory	74,233,324	696,033,162	0.106652	36,252,840		3,866,438	
9.	Blood							
10.	Blood - Administration	20,134,621	81,606,065	0.246729	8,603,023		2,122,615	
11.	Intravenous Therapy							
12.	Respiratory Therapy	16,394,251	148,229,591	0.110600	20,407,727		2,257,095	
13.	Physical Therapy	4,518,136	12,502,924	0.361366	1,304,667		471,462	
14.	Occupational Therapy	1,860,736	6,946,987	0.267848	563,694		150,984	
15.	Speech Pathology							
16.	EKG	4,291,553	28,806,804	0.148977	1,311,031		195,313	
17.	EEG	5,992,836	33,245,357	0.180261	1,599,902		288,400	
18.	Med. / Surg. Supplies	60,486,575	168,696,443	0.358553	10,221,531		3,664,961	
19.	Drugs Charged to Patients	69,042,736	280,558,994	0.246090	23,725,896		5,838,706	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	7,908,059	49,871,037	0.158570	1,657,473		262,825	
23.	Cardiology Graphics	8,701,841	83,855,474	0.103772	3,455,919		358,628	
24.	Pulmonary Function Testing	1,495,569	11,942,155	0.125234	243,873		30,541	
25.	MRI	23,903,055	182,553,083	0.130938	4,111,760		538,386	
26.	Vascular Lab & Cell Therapy	3,810,207	28,169,365	0.135261	1,556,919		210,590	
27.	CT & EPS	21,087,566	271,111,357	0.077782	9,601,329		746,811	
28.	Cast Room							
29.	GI Lab	15,683,327	77,373,149	0.202697	994,561		201,595	
30.	Transplant Clinic	3,240,315	5,393,048	0.600832	10,100		6,068	
31.	Transplant Acq (Liver/Kidney/Heart/P)	24,716,059	37,663,600	0.656232	1,645,200		1,079,633	
32.	OB & Psych Clinic	15,013,297	14,096,185	1.065061	13,158		14,014	
33.	Blood Flow Lab	8,498,973	36,777,825	0.231090	2,728,930		630,628	
34.	Implantable Devices	66,582,640	158,050,829	0.421274	5,183,620		2,183,724	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	5,329,053	4,080,846	1.305870	2,959		3,864	
44.	Emergency	30,009,144	166,853,183	0.179854	7,010,646		1,260,893	
45.	Observation	14,479,075	32,512,444	0.445339				
46.	Total				213,135,560		39,237,993	

* 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: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: 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)	238,859,200	10,703,935		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	188,167	9,792		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,269.40	1,093.13		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	24,798			
3.	Program general inpatient routine cost (Line 1c X Line 2)	31,478,581			
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)	31,478,581			

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	60,485,537	28,488	2,123.19	2,179	4,626,431
9.	Coronary Care Unit					
10.	Special Care Nursery	29,919,012	22,664	1,320.11	5,578	7,363,574
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	5,205,605	26,760	194.53	4,753	924,601
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					39,237,993
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					83,631,180

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

PRELIMINARY

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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)	
		(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:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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 Function 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/Pan)							
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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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**

BHF Page 7

PRELIMINARY

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

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)		83,631,180	
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)		3,844,943	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		87,476,123	
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)		213,135,560	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		66,033,602	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit		10,609,837	
F. Coronary Care Unit			
G. Special Care Nursery		24,768,252	
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		5,131,205	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		319,678,456	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			232,202,333
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: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2011 To: 08/31/2012

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)	87,476,123	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	87,476,123	
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)	87,476,123	

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:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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)	232,202,333
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

PRELIMINARY

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: 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

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:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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 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	13,203,338	613,530,931	0.021520	26,201,232		563,851	
2.	Recovery Room	611,761	51,586,066	0.011859	1,485,027		17,611	
3.	Delivery and Labor Room	2,179,769	148,979,517	0.014631	26,217,160		383,583	
4.	Anesthesiology	89,091	49,386,326	0.001804	2,151,246		3,881	
5.	Radiology - Diagnostic	4,003,172	282,439,837	0.014174	13,006,578		184,355	
6.	Radiology - Therapeutic	1,276,977	150,602,580	0.008479	1,053,000		8,928	
7.	Nuclear Medicine	172,243	65,224,856	0.002641	814,559		2,151	
8.	Laboratory	3,260,744	696,033,162	0.004685	36,252,840		169,845	
9.	Blood							
10.	Blood - Administration	249,456	81,606,065	0.003057	8,603,023		26,299	
11.	Intravenous Therapy							
12.	Respiratory Therapy	172,243	148,229,591	0.001162	20,407,727		23,714	
13.	Physical Therapy	17,818	12,502,924	0.001425	1,304,667		1,859	
14.	Occupational Therapy	17,818	6,946,987	0.002565	563,694		1,446	
15.	Speech Pathology							
16.	EKG							
17.	EEG	142,546	33,245,357	0.004288	1,599,902		6,860	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	344,487	49,871,037	0.006908	1,657,473		11,450	
23.	Cardiology Graphics	528,609	83,855,474	0.006304	3,455,919		21,786	
24.	Pulmonary Function Testing	196,001	11,942,155	0.016413	243,873		4,003	
25.	MRI							
26.	Vascular Lab & Cell Therapy							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab	332,607	77,373,149	0.004299	994,561		4,276	
30.	Transplant Clinic	296,971	5,393,048	0.055066	10,100		556	
31.	Transplant Acq (Liver/Kidney/Heart/P							
32.	OB & Psych Clinic	1,318,552	14,096,185	0.093540	13,158		1,231	
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	926,550	4,080,846	0.227049	2,959		672	
44.	Emergency	1,817,464	166,853,183	0.010893	7,010,646		76,367	
45.	Observation							
46.	Ancillary Total						1,514,724	

* 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:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	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	13,708,189	188,167	72.85	24,798		1,806,534	
48.	Psych	1,609,584	9,792	164.38				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	5,814,696	28,488	204.11	2,179		444,756	
52.	Coronary Care Unit							
53.	Special Care Nursery	320,729	22,664	14.15	5,578		78,929	
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)						2,330,219	
68.	Ancillary Total (from line 46)						1,514,724	
69.	Total (Lines 67-68)						3,844,943	

PRELIMINARY

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	32,555		32,555
Newborn Days	4,753		4,753
Total Inpatient Revenue	319,678,456		319,678,456
Ancillary Revenue	213,135,560		213,135,560
Routine Revenue	106,542,896		106,542,896
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.