

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: 09/01/2013	To: 08/31/2014	

Type of Control

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

Type of Hospital

☒ 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	☐ 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 Hosp 3122 for the cost report beginning 09/01/2013 and ending 08/31/2014 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

BHF Page 2

PRELIMINARY

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2013 To: 08/31/2014

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	660	240,643		171,883	71.43%		46,144	4.80
2.	Psych	29	10,585		8,293	78.35%		1,015	8.17
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	106	38,690		28,608	73.94%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,390		21,180	67.47%			
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		26,231	63.04%			
22.	Total	995	362,918		256,195	70.59%		47,159	4.88
23.	Observation Bed Days				9,274				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				19,090			6,666	3.85
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,501				
6.	Coronary Care Unit								
7.	Special Care Nursery				4,048				
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				3,371				
22.	Total				29,010	11.32%		6,666	3.85

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: 09/01/2013	To: 08/31/2014

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	82,759,809	732,690,316	0.112953	26,114,775		2,949,742	
2.	Recovery Room	15,110,227	59,487,553	0.254007	1,319,910		335,266	
3.	Delivery and Labor Room	33,250,692	128,942,143	0.257873	23,022,599		5,936,907	
4.	Anesthesiology	5,957,359	63,916,908	0.093205	2,207,794		205,777	
5.	Radiology - Diagnostic	49,217,662	303,745,625	0.162036	8,667,167		1,404,393	
6.	Radiology - Therapeutic	18,830,037	153,825,589	0.122412	587,434		71,909	
7.	Nuclear Medicine	7,478,780	59,707,965	0.125256	524,690		65,721	
8.	Laboratory	90,642,692	728,362,642	0.124447	24,002,447		2,987,033	
9.	Blood							
10.	Blood - Administration	9,724,747	39,500,054	0.246196	2,050,381		504,796	
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,324,371	132,043,303	0.055469	17,057,183		946,145	
13.	Physical Therapy	1,126,259	8,595,886	0.131023	574,872		75,321	
14.	Occupational Therapy	470,363	4,824,031	0.097504	294,254		28,691	
15.	Speech Pathology							
16.	EKG							
17.	EEG	5,530,095	43,795,042	0.126272	1,964,560		248,069	
18.	Med. / Surg. Supplies	61,432,645	163,763,449	0.375130	7,824,910		2,935,358	
19.	Drugs Charged to Patients	72,993,646	277,917,220	0.262645	16,550,480		4,346,901	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	3,985,440	55,417,560	0.071917	1,320,225		94,947	
23.	Cardiology Graphics	12,617,810	140,500,251	0.089806	4,207,934		377,898	
24.	Pulmonary Function Testing	1,763,505	12,478,866	0.141319	215,030		30,388	
25.	MRI	24,713,073	238,696,631	0.103533	3,591,063		371,794	
26.	Vascular Lab	2,054,368	30,844,995	0.066603	1,230,107		81,929	
27.	CT & EPS	18,918,793	319,826,480	0.059153	7,710,698		456,111	
28.	Cast Room							
29.	GI Lab	13,819,393	84,152,638	0.164218	820,247		134,699	
30.	Transplant Clinic	1,643,642	5,827,307	0.282059	213,086		60,103	
31.	Transplant Acq (Liver/Kidney/Heart/Pa	24,138,119	32,636,200	0.739612	1,537,400		1,137,079	
32.	OB & Psych Clinic	9,298,204	12,115,670	0.767453	129,317		99,245	
33.	Blood Flow Lab	17,059,483	62,781,491	0.271728	5,173,023		1,405,655	
34.	Implantable Devices	78,711,971	180,266,536	0.436642	5,065,529		2,211,823	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	5,029,596	4,999,560	1.006008	97,979		98,568	
44.	Emergency	25,986,524	221,503,286	0.117319	6,407,144		751,680	
45.	Observation	14,120,219	43,964,766	0.321171	264,156		84,839	
46.	Total				170,746,394		30,438,787	

* 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: 09/01/2013 To: 08/31/2014

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)	210,241,665	8,563,409		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	181,157	8,293		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,160.55	1,032.61		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	19,090			
3.	Program general inpatient routine cost (Line 1c X Line 2)	22,154,900			
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)	22,154,900			

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	55,873,680	28,608	1,953.08	2,501	4,884,653
9.	Coronary Care Unit					
10.	Special Care Nursery	25,310,423	21,180	1,195.02	4,048	4,837,441
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	4,203,270	26,231	160.24	3,371	540,169
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					30,438,787
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					62,855,950

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: 09/01/2013 To: 08/31/2014

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						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: 09/01/2013 To: 08/31/2014

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.	Cardiac Cath Lab							
23.	Cardiology Graphics							
24.	Pulmonary Function Testing							
25.	MRI							
26.	Vascular Lab							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab							
30.	Transplant Clinic							
31.	Transplant Acq (Liver/Kidney/Heart/Par							
32.	OB & Psych Clinic							
33.	Blood Flow Lab							
34.	Implantable Devices							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2013 To: 08/31/2014

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.	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: 09/01/2013 To: 08/31/2014	
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)	62,855,950	
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)	4,128,994	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	66,984,944	
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)	170,746,394	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	34,054,696	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	10,961,756	
	F. Coronary Care Unit		
	G. Special Care Nursery	13,925,900	
	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	2,509,081	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	232,197,827	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		165,212,883
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: 09/01/2013 To: 08/31/2014

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)	66,984,944	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	66,984,944	
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)	66,984,944	

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: 09/01/2013 To: 08/31/2014

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)	165,212,883
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 09/01/2013 To: 08/31/2014

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

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:	09/01/2013
		To:	08/31/2014

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	16,537,539	732,690,316	0.022571	26,114,775		589,437	
2.	Recovery Room	766,247	59,487,553	0.012881	1,319,910		17,002	
3.	Delivery and Labor Room	2,730,219	128,942,143	0.021174	23,022,599		487,481	
4.	Anesthesiology	111,589	63,916,908	0.001746	2,207,794		3,855	
5.	Radiology - Diagnostic	5,014,080	303,745,625	0.016507	8,667,167		143,069	
6.	Radiology - Therapeutic	1,599,447	153,825,589	0.010398	587,434		6,108	
7.	Nuclear Medicine	215,740	59,707,965	0.003613	524,690		1,896	
8.	Laboratory	4,084,170	728,362,642	0.005607	24,002,447		134,582	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	215,740	132,043,303	0.001634	17,057,183		27,871	
13.	Physical Therapy	14,879	8,595,886	0.001731	574,872		995	
14.	Occupational Therapy	22,318	4,824,031	0.004626	294,254		1,361	
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	178,543	163,763,449	0.001090	7,824,910		8,529	
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	431,479	55,417,560	0.007786	1,320,225		10,279	
23.	Cardiology Graphics	662,097	140,500,251	0.004712	4,207,934		19,828	
24.	Pulmonary Function Testing	245,497	12,478,866	0.019673	215,030		4,230	
25.	MRI							
26.	Vascular Lab							
27.	CT & EPS							
28.	Cast Room							
29.	GI Lab	416,600	84,152,638	0.004951	820,247		4,061	
30.	Transplant Clinic	371,965	5,827,307	0.063831	213,086		13,601	
31.	Transplant Acq (Liver/Kidney/Heart/Pancreas)							
32.	OB & Psych Clinic	1,651,523	12,115,670	0.136313	129,317		17,628	
33.	Blood Flow Lab	312,450	62,781,491	0.004977	5,173,023		25,746	
34.	Implantable Devices							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	1,160,529	4,999,560	0.232126	97,979		22,743	
44.	Emergency	2,276,423	221,503,286	0.010277	6,407,144		65,846	
45.	Observation							
46.	Ancillary Total						1,606,148	

* 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: 09/01/2013 To: 08/31/2014

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	17,169,873	181,157	94.78	19,090		1,809,350	
48.	Psych	2,016,047	8,293	243.10				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	7,283,064	28,608	254.58	2,501		636,705	
52.	Coronary Care Unit							
53.	Special Care Nursery	401,722	21,180	18.97	4,048		76,791	
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)						2,522,846	
68.	Ancillary Total (from line 46)						1,606,148	
69.	Total (Lines 67-68)						4,128,994	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2013 To: 08/31/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	25,639		25,639
Newborn Days	3,371		3,371
Total Inpatient Revenue	232,197,827		232,197,827
Ancillary Revenue	170,746,394		170,746,394
Routine Revenue	61,451,433		61,451,433
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 Flow Lab to agree with prior year.