

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		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: 07/01/2014	To: 06/30/2015

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County
		☐ Township
		☐ Hospital District
		☐ 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)) University of Illinois Hospital , 3098 for the cost report beginning 07/01/2014 and ending 06/30/2015 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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 07/01/2014 To: 06/30/2015

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	312	113,880		65,548	57.56%		20,549	4.76
2.	Psych	53	19,345		12,746	65.89%		1,078	11.82
3.	Rehab	18	6,570		3,753	57.12%		323	11.62
4.	Other (Sub)								
5.	Intensive Care Unit	45	16,425		11,863	72.23%			
6.	Coronary Care Unit	19	6,935		4,946	71.32%			
7.	Pediatric ICU	18	6,570		2,793	42.51%			
8.	Neonatal ICU	52	18,980		12,618	66.48%			
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		3,937	43.15%			
22.	Total	542	197,830		118,204	59.75%		21,950	5.21
23.	Observation Bed Days				5,849				

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Part II-Program								
1. Adults and Pediatrics								
2. Psych								
3. Rehab				877			54	16.24
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				877	0.74%		54	16.24

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:	
14-0150		3098	
Program:		Period Covered by Statement:	
Medicaid-Rehab		From: 07/01/2014	To: 06/30/2015

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	40,323,596	149,496,274	0.269730	15,078		4,067	
2.	Recovery Room	7,895,424	12,576,946	0.627770	1,967		1,235	
3.	Delivery and Labor Room	12,323,081	23,838,814	0.516933				
4.	Anesthesiology	3,645,663	62,802,180	0.058050	7,955		462	
5.	Radiology - Diagnostic	6,606,586	29,740,898	0.222138	7,183		1,596	
6.	Radiology - Therapeutic	8,699,879	22,575,578	0.385367				
7.	Nuclear Medicine	1,740,279	7,410,870	0.234828				
8.	Laboratory	39,995,708	284,837,963	0.140416	98,987		13,899	
9.	Blood							
10.	Blood - Administration	7,697,361	28,865,041	0.266667	5,679		1,514	
11.	Intravenous Therapy	545,914	1,492,955	0.365660	134		49	
12.	Respiratory Therapy	6,335,663	37,796,658	0.167625	9,014		1,511	
13.	Physical Therapy	9,471,785	21,233,392	0.446080	395,152		176,269	
14.	Occupational Therapy	3,215,820	6,470,816	0.496973	335,324		166,647	
15.	Speech Pathology	915,065	1,746,218	0.524027	66,783		34,996	
16.	EKG	530,552	4,674,610	0.113497	2,333		265	
17.	EEG	663,859	6,313,737	0.105145	497		52	
18.	Med. / Surg. Supplies	68,302,954	196,211,083	0.348110	87,921		30,606	
19.	Drugs Charged to Patients	72,682,520	265,093,975	0.274176	385,640		105,733	
20.	Renal Dialysis	9,321,809	31,150,963	0.299246				
21.	Ambulance							
22.	Ultrasound	2,340,259	12,390,979	0.188868	5,851		1,105	
23.	Radiology Angiography	6,312,221	57,754,270	0.109294	2,168		237	
24.	Radiology W. Harrison	2,775,662	14,387,888	0.192917	3,500		675	
25.	CT Scan	4,783,047	65,662,623	0.072843	28,904		2,105	
26.	MRI	4,882,771	47,026,721	0.103830	24,637		2,558	
27.	Cardiac Catheterization	2,724,133	16,643,814	0.163672				
28.	Lab Tissue Typing	1,437,421	4,162,271	0.345345				
29.	Lab Outreach	12,676,742	146,422,457	0.086576				
30.	Gastroenterology	4,600,488	24,627,495	0.186803	2,227		416	
31.	Bone Marrow Transplant	3,493,463	3,605,036	0.969051				
32.	Cardiac Services	4,311,812	22,309,230	0.193275	12,661		2,447	
33.	Kidney Acquisition	6,311,506	7,554,816	0.835428				
34.	Liver Acquisition	1,496,080	2,077,422	0.720162				
35.	Pancreas Acquisition	779,898	1,093,380	0.713291				
36.	Other Organ Acquisition	448,893	79,542	5.643471				
37.	Radio Mile Square	531,886	1,661,378	0.320147				
38.	Telemedicine Prgm	2,275,244	1,486,292	1.530819				
39.	Sleep Lab West Harr	1,457,925	4,103,681	0.355272				
40.	Sickle Cell Clinic	665,125	3,376,313	0.196997				
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	85,153,218	135,493,419	0.628468				
44.	Emergency	17,388,355	84,928,285	0.204742				
45.	Observation	8,819,883	12,369,113	0.713057				
46.	Total				1,499,595		548,444	

* 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-Rehab	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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)	107,661,828	16,271,852	5,793,549	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	71,397	12,746	3,753	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,507.93	1,276.62	1,543.71	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			877	
3.	Program general inpatient routine cost (Line 1c X Line 2)			1,353,834	
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)			1,353,834	

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	28,685,095	11,863	2,418.03		
9.	Coronary Care Unit	12,948,252	4,946	2,617.92		
10.	Pediatric ICU	8,390,079	2,793	3,003.97		
11.	Neonatal ICU	23,982,760	12,618	1,900.68		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,711,266	3,937	688.66		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					548,444
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,902,278

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-Rehab	Period Covered by Statement:	From: 07/01/2014 To: 06/30/2015

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.	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) (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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehab	Period Covered by Statement:	From: 07/01/2014 To: 06/30/2015

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.	Other Organ Acquisition							
37.	Radio Mile Square							
38.	Telemedicine Prgm							
39.	Sleep Lab West Harr							
40.	Sickle Cell Clinic							
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-Rehab	Period Covered by Statement:	From: 07/01/2014 To: 06/30/2015

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-Rehab		Period Covered by Statement: From: 07/01/2014 To: 06/30/2015	
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)	1,902,278	
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)	53,007	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,955,285	
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)	1,499,595	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	1,539,256	
	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)	3,038,851	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,083,566
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-Rehab	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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)	1,955,285	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,955,285	
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)	1,955,285	

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:	Medicaid Provider Number:
14-0150	3098
Program:	Period Covered by Statement:
Medicaid-Rehab	From: 07/01/2014 To: 06/30/2015

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)	1,083,566
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: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Rehab	Period Covered by Statement:	
		From:	07/01/2014 To: 06/30/2015

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	8,594,453	149,496,274	0.057489	15,078		867	
2.	Recovery Room	120,512	12,576,946	0.009582	1,967		19	
3.	Delivery and Labor Room	1,212,851	23,838,814	0.050877				
4.	Anesthesiology	2,183,489	62,802,180	0.034768	7,955		277	
5.	Radiology - Diagnostic	284,977	29,740,898	0.009582	7,183		69	
6.	Radiology - Therapeutic	2,240,477	22,575,578	0.099243				
7.	Nuclear Medicine	292,230	7,410,870	0.039433				
8.	Laboratory	9,360,314	284,837,963	0.032862	98,987		3,253	
9.	Blood							
10.	Blood - Administration	1,614,963	28,865,041	0.055949	5,679		318	
11.	Intravenous Therapy	14,305	1,492,955	0.009582	134		1	
12.	Respiratory Therapy	1,811,155	37,796,658	0.047918	9,014		432	
13.	Physical Therapy	507,636	21,233,392	0.023907	395,152		9,447	
14.	Occupational Therapy	222,387	6,470,816	0.034368	335,324		11,524	
15.	Speech Pathology	171,586	1,746,218	0.098261	66,783		6,562	
16.	EKG	498,292	4,674,610	0.106595	2,333		249	
17.	EEG	60,498	6,313,737	0.009582	497		5	
18.	Med. / Surg. Supplies	3,799,174	196,211,083	0.019363	87,921		1,702	
19.	Drugs Charged to Patients	11,305,950	265,093,975	0.042649	385,640		16,447	
20.	Renal Dialysis	1,460,051	31,150,963	0.046870				
21.	Ambulance							
22.	Ultrasound	323,358	12,390,979	0.026096	5,851		153	
23.	Radiology Angiography	2,195,955	57,754,270	0.038022	2,168		82	
24.	Radiology W. Harrison	137,865	14,387,888	0.009582	3,500		34	
25.	CT Scan	1,585,953	65,662,623	0.024153	28,904		698	
26.	MRI	1,385,262	47,026,721	0.029457	24,637		726	
27.	Cardiac Catheterization	2,172,578	16,643,814	0.130534				
28.	Lab Tissue Typing	39,883	4,162,271	0.009582				
29.	Lab Outreach	1,403,020	146,422,457	0.009582				
30.	Gastroenterology	235,981	24,627,495	0.009582	2,227		21	
31.	Bone Marrow Transplant	34,543	3,605,036	0.009582				
32.	Cardiac Services	213,767	22,309,230	0.009582	12,661		121	
33.	Kidney Acquisition	337,853	7,554,816	0.044720				
34.	Liver Acquisition	263,247	2,077,422	0.126718				
35.	Pancreas Acquisition	10,477	1,093,380	0.009582				
36.	Other Organ Acquisition	56,067	79,542	0.704873				
37.	Radio Mile Square	15,919	1,661,378	0.009582				
38.	Telemedicine Prgm	14,242	1,486,292	0.009582				
39.	Sleep Lab West Harr	39,321	4,103,681	0.009582				
40.	Sickle Cell Clinic	32,352	3,376,313	0.009582				
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	4,146,498	135,493,419	0.030603				
44.	Emergency	2,423,154	84,928,285	0.028532				
45.	Observation							
46.	Ancillary Total						53,007	

* 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-Rehab	Period Covered by Statement:	From: 07/01/2014 To: 06/30/2015

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	6,782,076	71,397	94.99				
48.	Psych	962,309	12,746	75.50				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,279,362	11,863	107.84				
52.	Coronary Care Unit	951,566	4,946	192.39				
53.	Pediatric ICU	577,763	2,793	206.86				
54.	Neonatal ICU	2,022,081	12,618	160.25				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	163,308	3,937	41.48				
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)						53,007	
69.	Total (Lines 67-68)						53,007	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
Program: Medicaid-Rehab	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	877		877
Newborn Days			
Total Inpatient Revenue	3,038,852	(1)	3,038,851
Ancillary Revenue	1,499,596	(1)	1,499,595
Routine Revenue	1,539,256		1,539,256
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".

\$1.00 adjustment is due to the rounding error.