Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

Preliminary

Name of Hospital: University of Wisconsin Hospitals and Clinics			**Medicare Provider Number:** 52-0098
Street: 600 Highland Avenue			**Medicaid Provider Number:** 13031
City: Madison	**State:** Wisconsin	**Zip:** 53792	
Period Covered by Statement:	**From:** 07/01/2013	**To:** 06/30/2014	

Type of Control

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

Type of Hospital

[XXXX]	General Short-Term	[ ]	Psychiatric	[ ]	Cancer
[ ]	General Long-Term	[ ]	Rehabilitation	[ ]	Other (Specify)

Health Care Program

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

[XXXX]	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 Wisconsin Hospi 13031 for the cost report beginning 07/01/2013 and ending 06/30/2014 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Name (Typewritten)

Title

Date

Telephone Number

Email Address

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	410	145,690		110,944	76.15%		26,935	5.03
2.	Psych	18	6,570		4,842	73.70%		1,081	4.48
3.	Rehab	21	7,665		5,972	77.91%		464	12.87
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,902	90.21%			
8.	Cardio Surgery ICU	9	3,285		2,238	68.13%			
9.	Cardiac ICU	7	2,555		1,751	68.53%			
10.	Pediatric ICU	21	7,665		5,129	66.91%			
11.	Neuro ICU	16	5,840		5,167	88.48%			
12.	Neonatal ICU	14	686		222	32.36%			
13.	Burn ICU	7	2,555		2,058	80.55%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**547**	**191,271**		**146,225**	**76.45%**		**28,480**	**5.13**
23.	Observation Bed Days				5,084				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,308			214	7.77
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				123				
8.	Cardio Surgery ICU				13				
9.	Cardiac ICU				4				
10.	Pediatric ICU				131				
11.	Neuro ICU				47				
12.	Neonatal ICU								
13.	Burn ICU				37				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**1,663**	**1.14%**		**214**	**7.77**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	2,678	952,871

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	98,867,958	436,721,758	0.226387	2,471,533	896,427	559,523	202,939
2.	Recovery Room	17,139,139	50,381,000	0.340191	231,103	210,933	78,619	71,758
3.	Delivery and Labor Room							
4.	Anesthesiology	13,759,556	34,965,709	0.393516	219,035	98,806	86,194	38,882
5.	Radiology - Diagnostic	43,281,021	144,526,798	0.299467	694,033	544,975	207,840	163,202
6.	Radiology - Therapeutic	11,495,658	75,853,251	0.151551	44,444	146,446	6,736	22,194
7.	Nuclear Medicine	5,995,579	19,681,360	0.304632	12,156	124,988	3,703	38,075
8.	Laboratory	60,244,372	301,610,398	0.199742	1,374,819	611,718	274,609	122,186
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	21,859,135	57,419,145	0.380694	537,892	10,766	204,772	4,099
13.	Physical Therapy	29,335,631	73,092,223	0.401351	375,618	45,805	150,755	18,384
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	34,930,158	142,419,283	0.245263	255,879	334,569	62,758	82,057
17.	EEG	3,005,722	13,320,362	0.225649	65,556	41,425	14,793	9,348
18.	Med. / Surg. Supplies	1,658,604	2,996,560	0.553503	35,400	2,310	19,594	1,279
19.	Drugs Charged to Patients	183,799,798	448,513,699	0.409798	1,918,983	547,659	786,395	224,430
20.	Renal Dialysis	4,149,561	7,572,822	0.547954	24,262	2,888	13,294	1,582
21.	Ambulance	6,885,850	15,938,396	0.432029	177,231		76,569	
22.	CT Scan	10,305,521	152,316,484	0.067659	432,191	498,558	29,242	33,732
23.	MRI	10,647,753	111,749,957	0.095282	326,242	381,582	31,085	36,358
24.	Cardiac Rehab	1,458,513	1,906,205	0.765140				
25.	Neuropsych Testing	786,117	1,563,153	0.502905	589	198	296	100
26.	Clinic-CSC	79,691,980	113,186,211	0.704079	140,514	719,348	98,933	506,478
27.	Clinic-University Station	17,741,216	18,348,457	0.966905	289	38,304	279	37,036
28.	Clinic-Waisman	2,768,052	2,119,831	1.305789		36,273		47,365
29.	Clinic-West	28,582,076	34,134,213	0.837344	4,018	26,351	3,364	22,065
30.	Clinic-East	17,223,185	16,574,804	1.039118		20,341		21,137
31.	Clinic-Research Park	6,504,680	7,332,305	0.887126		6,915		6,134
32.	Pulmonary Function	812,390	3,428,144	0.236977	4,731	23,559	1,121	5,583
33.	Orthotics	2,362,604	3,505,534	0.673964	9,225	8,620	6,217	5,810
34.	Implantable Devices	39,985,812	49,871,190	0.801782	127,586	37,932	102,296	30,413
35.	Clinic-DHC	18,248,482	39,949,403	0.456790		15,681		7,163
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	21,616,100	90,242,241	0.239534	124,477	142,268	29,816	34,078
45.	Observation	6,244,830	21,521,207	0.290171		174,176		50,541
46.	**Total**				**9,607,806**	**5,749,821**	**2,848,803**	**1,844,408**

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	142,521,028	4,761,422	6,283,290	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	116,028	4,842	5,972	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,228.33	983.36	1,052.12	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,308			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,606,656			
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)	1,606,656			

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					
9.	Coronary Care Unit					
10.	Trauma ICU	20,448,616	7,902	2,587.78	123	318,297
11.	Cardio Surgery ICU	13,867,215	2,238	6,196.25	13	80,551
12.	Cardiac ICU	4,500,073	1,751	2,570.00	4	10,280
13.	Pediatric ICU	13,565,583	5,129	2,644.88	131	346,479
14.	Neuro ICU	12,655,436	5,167	2,449.28	47	115,116
15.	Neonatal ICU	2,743,252	222	12,356.99		
16.	Burn ICU	5,592,131	2,058	2,717.26	37	100,539
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,848,803
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,426,721**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Trauma ICU						
9.	Cardio Surgery ICU						
10.	Cardiac ICU						
11.	Pediatric ICU						
12.	Neuro ICU						
13.	Neonatal ICU						
14.	Burn ICU						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Rehab							
25.	Neuropsych Testing							
26.	Clinic-CSC							
27.	Clinic-University Station							
28.	Clinic-Waisman							
29.	Clinic-West							
30.	Clinic-East							
31.	Clinic-Research Park							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implantable Devices							
35.	Clinic-DHC							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Neonatal ICU							
59.	Burn ICU							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		1,844,408
2.	Inpatient Operating Services (BHF Page 4, Line 25)	5,426,721	
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)	464,000	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**5,890,721**	**1,844,408**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	76.00%	24.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	9,607,806	5,749,821
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,217,481	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU	887,204	
	H. Cardio Surgery ICU	62,580	
	I. Cardiac ICU	29,714	
	J. Pediatric ICU	915,812	
	K. Neuro ICU	310,092	
	L. Neonatal ICU		
	M. Burn ICU	147,841	
	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)**	15,178,530	5,749,821
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		13,193,222
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	5,890,721	1,844,408
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,890,721	1,844,408
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)**	**5,890,721**	**1,844,408**

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

* Line 9 DOES NOT APPLY to the Medicaid program.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	13,193,222
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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
52-0098	**13031**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2013 To: 06/30/2014**

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1.	Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3.	Total Per Diem (Line 1 Plus Line 2)	

	Part B. Program Data	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
4.	Program inpatient days (BHF Page 2, Part II, Column 4)				
5.	Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

	Part C. Program Cost	**General Service**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
6.	Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7.	Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

		Adults and Pediatrics	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	Gross Routine Revenues				
	(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
	(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2.	Routine Days				
	(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
	(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3.	Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6.	**Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))**				
7.	Private room cost differential adjustment (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9.	**Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)**				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
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.	CT Scan							
23.	MRI							
24.	Cardiac Rehab							
25.	Neuropsych Testing							
26.	Clinic-CSC							
27.	Clinic-University Station							
28.	Clinic-Waisman							
29.	Clinic-West							
30.	Clinic-East							
31.	Clinic-Research Park							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implantable Devices							
35.	Clinic-DHC							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary 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 G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
47.	Adults and Pediatrics	41,159,855	116,028	354.74	1,308		464,000	
48.	Psych	307,141	4,842	63.43				
49.	Rehab	145,593	5,972	24.38				
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Neonatal ICU							
59.	Burn ICU							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**464,000**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**464,000**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2013 To: 06/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,704	(41)	1,663
Newborn Days			
Total Inpatient Revenue	15,179,001	(471)	15,178,530
Ancillary Revenue	9,608,277	(471)	9,607,806
Routine Revenue	5,570,724		5,570,724
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	2,678		2,678
Total Outpatient Revenue	5,750,801	(980)	5,749,821
Outpatient Received and Receivable			

Notes:

BHF P.3 - Removed Cardiac Rehab. I/P ($471) & O/P ($980) Charges since they are not covered by IL Medicaid.

BHF Page 2 - Included 41 Medicaid filed Rehab days with Adults and Peds.