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 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	XXXX XXXX	State		Township
	Corporation		Partnership		City		Hospital District
	Other (Specify)		Corporation		County		Other (Specify)

Type of Hospital

XXXX 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 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 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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				13,582			4,855	5.01
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,222				
6.	Coronary Care Unit				923				
7.	Pediatric ICU				1,767				
8.	Neonatal ICU				6,826				
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				1,531				
22.	**Total**				**25,851**	**21.87%**		**4,855**	**5.01**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	126,080	471,598

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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	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	40,323,596	149,496,274	0.269730	14,548,300	13,330,532	3,924,113	3,595,644
2.	Recovery Room	7,895,424	12,576,946	0.627770	741,529	1,337,343	465,510	839,544
3.	Delivery and Labor Room	12,323,081	23,838,814	0.516933	6,802,515	1,334,869	3,516,444	690,038
4.	Anesthesiology	3,645,663	62,802,180	0.058050	7,465,283	5,197,552	433,360	301,718
5.	Radiology - Diagnostic	6,606,586	29,740,898	0.222138	1,503,633	2,858,875	334,014	635,065
6.	Radiology - Therapeutic	8,699,879	22,575,578	0.385367	383,293	3,167,782	147,708	1,220,759
7.	Nuclear Medicine	1,740,279	7,410,870	0.234828	261,066	636,893	61,306	149,560
8.	Laboratory	39,995,708	284,837,963	0.140416	19,517,072	28,814,955	2,740,509	4,046,081
9.	Blood							
10.	Blood - Administration	7,697,361	28,865,041	0.266667	3,796,227	1,079,506	1,012,328	287,869
11.	Intravenous Therapy	545,914	1,492,955	0.365660	146,948	6	53,733	2
12.	Respiratory Therapy	6,335,663	37,796,658	0.167625	10,491,201	446,263	1,758,588	74,805
13.	Physical Therapy	9,471,785	21,233,392	0.446080	766,622	2,832,888	341,975	1,263,695
14.	Occupational Therapy	3,215,820	6,470,816	0.496973	535,184	431,326	265,972	214,357
15.	Speech Pathology	915,065	1,746,218	0.524027	277,513	229,228	145,424	120,122
16.	EKG	530,552	4,674,610	0.113497	399,796	256,179	45,376	29,076
17.	EEG	663,859	6,313,737	0.105145	1,056,168	88,971	111,051	9,355
18.	Med. / Surg. Supplies	68,302,954	196,211,083	0.348110	19,317,366	9,128,388	6,724,568	3,177,683
19.	Drugs Charged to Patients	72,682,520	265,093,975	0.274176	31,080,470	5,890,667	8,521,519	1,615,080
20.	Renal Dialysis	9,321,809	31,150,963	0.299246	612,521	2,427,695	183,294	726,478
21.	Ambulance							
22.	Ultrasound	2,340,259	12,390,979	0.188868	896,739	1,156,008	169,365	218,333
23.	Radiology Angiography	6,312,221	57,754,270	0.109294	4,954,752	1,955,912	541,525	213,769
24.	Radiology W. Harrison	2,775,662	14,387,888	0.192917	1,337	1,900,426	258	366,624
25.	CT Scan	4,783,047	65,662,623	0.072843	4,180,399	4,991,874	304,513	363,623
26.	MRI	4,882,771	47,026,721	0.103830	2,700,138	4,636,938	280,355	481,453
27.	Cardiac Catheterization	2,724,133	16,643,814	0.163672	967,315	480,849	158,322	78,702
28.	Lab Tissue Typing	1,437,421	4,162,271	0.345345	34,387	197,774	11,875	68,300
29.	Lab Outreach	12,676,742	146,422,457	0.086576				
30.	Gastroenterology	4,600,488	24,627,495	0.186803	737,723	1,653,210	137,809	308,825
31.	Bone Marrow Transplant	3,493,463	3,605,036	0.969051	162,347	20,160	157,323	19,536
32.	Cardiac Services	4,311,812	22,309,230	0.193275	2,044,112	1,005,878	395,076	194,411
33.	Kidney Acquisition	6,311,506	7,554,816	0.835428	314,784		262,979	
34.	Liver Acquisition	1,496,080	2,077,422	0.720162	218,676		157,482	
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		671,958		238,728
40.	Sickle Cell Clinic	665,125	3,376,313	0.196997	68,221	306,818	13,439	60,442
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	85,153,218	135,493,419	0.628468	13,068	23,646,782	8,213	14,861,246
44.	Emergency	17,388,355	84,928,285	0.204742	5,073,708	12,924,513	1,038,801	2,646,191
45.	Observation	8,819,883	12,369,113	0.713057	69,921	2,539,444	49,858	1,810,768
46.	**Total**				**142,140,334**	**137,578,462**	**34,473,985**	**40,927,882**

* 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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	13,582			
3.	Program general inpatient routine cost (Line 1c X Line 2)	20,480,705			
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)	20,480,705			

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	1,222	2,954,833
9.	Coronary Care Unit	12,948,252	4,946	2,617.92	923	2,416,340
10.	Pediatric ICU	8,390,079	2,793	3,003.97	1,767	5,308,015
11.	Neonatal ICU	23,982,760	12,618	1,900.68	6,826	12,974,042
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	1,531	1,054,338
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					34,473,985
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**79,662,258**

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

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.	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 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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)		40,927,882
2.	Inpatient Operating Services (BHF Page 4, Line 25)	79,662,258	
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)	8,571,905	4,670,427
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**88,234,163**	**45,598,309**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	66.00%	34.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	142,140,334	137,578,462
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	27,229,912	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,414,194	
	F. Coronary Care Unit	3,618,667	
	G. Pediatric ICU	6,160,212	
	H. Neonatal ICU	23,004,255	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,687,256	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	208,254,830	137,578,462
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		212,000,820
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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2014 To: 06/30/2015

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)	88,234,163	45,598,309
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	88,234,163	45,598,309
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)**	**88,234,163**	**45,598,309**

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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	212,000,820
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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:**
14-0150	**3098**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**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:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	14,548,300	13,330,532	836,367	766,359
2.	Recovery Room	120,512	12,576,946	0.009582	741,529	1,337,343	7,105	12,814
3.	Delivery and Labor Room	1,212,851	23,838,814	0.050877	6,802,515	1,334,869	346,092	67,914
4.	Anesthesiology	2,183,489	62,802,180	0.034768	7,465,283	5,197,552	259,553	180,708
5.	Radiology - Diagnostic	284,977	29,740,898	0.009582	1,503,633	2,858,875	14,408	27,394
6.	Radiology - Therapeutic	2,240,477	22,575,578	0.099243	383,293	3,167,782	38,039	314,380
7.	Nuclear Medicine	292,230	7,410,870	0.039433	261,066	636,893	10,295	25,115
8.	Laboratory	9,360,314	284,837,963	0.032862	19,517,072	28,814,955	641,370	946,917
9.	Blood							
10.	Blood - Administration	1,614,963	28,865,041	0.055949	3,796,227	1,079,506	212,395	60,397
11.	Intravenous Therapy	14,305	1,492,955	0.009582	146,948	6	1,408	
12.	Respiratory Therapy	1,811,155	37,796,658	0.047918	10,491,201	446,263	502,717	21,384
13.	Physical Therapy	507,636	21,233,392	0.023907	766,622	2,832,888	18,328	67,726
14.	Occupational Therapy	222,387	6,470,816	0.034368	535,184	431,326	18,393	14,824
15.	Speech Pathology	171,586	1,746,218	0.098261	277,513	229,228	27,269	22,524
16.	EKG	498,292	4,674,610	0.106595	399,796	256,179	42,616	27,307
17.	EEG	60,498	6,313,737	0.009582	1,056,168	88,971	10,120	853
18.	Med. / Surg. Supplies	3,799,174	196,211,083	0.019363	19,317,366	9,128,388	374,042	176,753
19.	Drugs Charged to Patients	11,305,950	265,093,975	0.042649	31,080,470	5,890,667	1,325,551	251,231
20.	Renal Dialysis	1,460,051	31,150,963	0.046870	612,521	2,427,695	28,709	113,786
21.	Ambulance							
22.	Ultrasound	323,358	12,390,979	0.026096	896,739	1,156,008	23,401	30,167
23.	Radiology Angiography	2,195,955	57,754,270	0.038022	4,954,752	1,955,912	188,390	74,368
24.	Radiology W. Harrison	137,865	14,387,888	0.009582	1,337	1,900,426	13	18,210
25.	CT Scan	1,585,953	65,662,623	0.024153	4,180,399	4,991,874	100,969	120,569
26.	MRI	1,385,262	47,026,721	0.029457	2,700,138	4,636,938	79,538	136,590
27.	Cardiac Catheterization	2,172,578	16,643,814	0.130534	967,315	480,849	126,267	62,767
28.	Lab Tissue Typing	39,883	4,162,271	0.009582	34,387	197,774	329	1,895
29.	Lab Outreach	1,403,020	146,422,457	0.009582				
30.	Gastroenterology	235,981	24,627,495	0.009582	737,723	1,653,210	7,069	15,841
31.	Bone Marrow Transplant	34,543	3,605,036	0.009582	162,347	20,160	1,556	193
32.	Cardiac Services	213,767	22,309,230	0.009582	2,044,112	1,005,878	19,587	9,638
33.	Kidney Acquisition	337,853	7,554,816	0.044720	314,784		14,077	
34.	Liver Acquisition	263,247	2,077,422	0.126718	218,676		27,710	
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		671,958		6,439
40.	Sickle Cell Clinic	32,352	3,376,313	0.009582	68,221	306,818	654	2,940
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	4,146,498	135,493,419	0.030603	13,068	23,646,782	400	723,662
44.	Emergency	2,423,154	84,928,285	0.028532	5,073,708	12,924,513	144,763	368,762
45.	Observation							
46.	**Ancillary Total**						**5,449,500**	**4,670,427**

* 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:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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	13,582		1,290,154	
48.	Psych	962,309	12,746	75.50				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,279,362	11,863	107.84	1,222		131,780	
52.	Coronary Care Unit	951,566	4,946	192.39	923		177,576	
53.	Pediatric ICU	577,763	2,793	206.86	1,767		365,522	
54.	Neonatal ICU	2,022,081	12,618	160.25	6,826		1,093,867	
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	1,531		63,506	
67.	**Routine Total (lines 47-66)**						**3,122,405**	
68.	**Ancillary Total (from line 46)**						**5,449,500**	**4,670,427**
69.	**Total (Lines 67-68)**						**8,571,905**	**4,670,427**

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

PRELIMINARY

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

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	24,320		24,320
Newborn Days	1,531		1,531
Total Inpatient Revenue	208,254,831	(1)	208,254,830
Ancillary Revenue	142,140,335	(1)	142,140,334
Routine Revenue	66,114,496		66,114,496
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	126,080		126,080
Total Outpatient Revenue	137,578,462		137,578,462
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 adjustement is due to the rounding error.