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:** 07/01/2016	**To:** 06/30/2017	

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	[ ]	
[ ]	Medicaid Sub I Psych	[ ]	Medicaid Sub III Other	[ ]	

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 07/01/2016 and ending 06/30/2017 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

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

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: 07/01/2016 To: 06/30/2017

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		64,893	56.98%		19,224	4.99
2.	Psych	53	19,345		12,060	62.34%		919	13.12
3.	Rehab	18	6,570		3,431	52.22%		361	9.50
4.	Other (Sub)								
5.	Intensive Care Unit	45	16,425		13,328	81.14%			
6.	Coronary Care Unit	19	6,935		5,694	82.11%			
7.	Pediatric ICU	18	6,570		1,711	26.04%			
8.	Neonatal ICU	52	18,980		10,363	54.60%			
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				3,810				
22.	**Total**	**517**	**188,705**		**115,290**	**61.10%**		**20,504**	**5.44**
23.	Observation Bed Days				7,655				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,093			1,575	5.02
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				908				
6.	Coronary Care Unit				344				
7.	Pediatric ICU				519				
8.	Neonatal ICU				1,044				
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				289				
22.	**Total**				**8,197**	**7.11%**		**1,575**	**5.02**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	146,056	546,317

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: 07/01/2016 To: 06/30/2017

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	45,162,954	161,810,361	0.279110	4,665,346	4,342,629	1,302,145	1,212,071
2.	Recovery Room	9,154,829	13,739,724	0.666304	296,106	454,731	197,297	302,989
3.	Delivery and Labor Room	17,606,572	33,224,607	0.529926	2,225,879	539,293	1,179,551	285,785
4.	Anesthesiology	4,135,253	73,512,931	0.056252	2,658,182	1,891,467	149,528	106,399
5.	Radiology - Diagnostic	8,041,657	33,170,031	0.242437	673,032	857,957	163,168	208,001
6.	Radiology - Therapeutic	8,923,156	18,019,094	0.495206	163,681	907,307	81,056	449,304
7.	Nuclear Medicine	1,966,469	7,123,494	0.276054	89,289	142,863	24,649	39,438
8.	Laboratory	44,613,682	337,680,863	0.132118	9,370,258	10,651,906	1,237,980	1,407,309
9.	Blood							
10.	Blood - Administration	8,592,599	38,713,298	0.221955	2,106,854	652,213	467,627	144,762
11.	Intravenous Therapy	630,214	3,520,721	0.179001	217,098	6,920	38,861	1,239
12.	Respiratory Therapy	7,589,436	43,129,953	0.175967	3,653,807	184,542	642,949	32,473
13.	Physical Therapy	12,286,630	25,093,302	0.489638	452,987	511,418	221,800	250,410
14.	Occupational Therapy	4,328,953	8,021,159	0.539692	254,375	237,359	137,284	128,101
15.	Speech Pathology	1,067,622	2,103,237	0.507609	129,491	135,544	65,731	68,803
16.	EKG	536,495	5,015,833	0.106960	193,578	90,331	20,705	9,662
17.	EEG	863,218	8,327,159	0.103663	635,534	55,403	65,881	5,743
18.	Med. / Surg. Supplies	73,511,149	200,027,869	0.367505	7,676,319	3,176,079	2,821,086	1,167,225
19.	Drugs Charged to Patients	88,070,313	314,227,014	0.280276	11,904,314	2,140,994	3,336,494	600,069
20.	Renal Dialysis	10,454,849	36,096,391	0.289637	690,554	463,654	200,010	134,291
21.	Ambulance							
22.	Ultrasound	2,650,637	14,832,773	0.178701	454,501	412,989	81,220	73,802
23.	Radiology Angiography	7,290,104	65,900,729	0.110623	3,236,003	599,644	357,976	66,334
24.	Radiology W. Harrison	2,810,006	15,997,524	0.175653	5,251	440,922	922	77,449
25.	CT Scan	6,343,355	94,139,156	0.067383	2,894,502	1,920,564	195,040	129,413
26.	MRI	6,105,513	57,011,358	0.107093	1,552,585	1,732,622	166,271	185,552
27.	Cardiac Catheterization	2,517,604	18,277,664	0.137742	745,688	118,929	102,713	16,382
28.	Lab Tissue Typing	1,791,411	5,158,958	0.347243	32,992	70,335	11,456	24,423
29.	Lab Outreach	13,134,343	160,098,876	0.082039				
30.	Gastroenterology	6,274,832	28,019,090	0.223948	368,127	432,638	82,441	96,888
31.	Bone Marrow Transplant	2,672,402	3,105,667	0.860492	159,235	4,300	137,020	3,700
32.	Cardiac Services	5,649,124	33,863,478	0.166821	1,103,185	447,682	184,034	74,683
33.	Kidney Acquisition	11,004,073	11,105,664	0.990852	260,289		257,908	
34.	Liver Acquisition	1,642,031	3,134,170	0.523913	247,117		129,468	
35.	Pancreas Acquisition	588,838	964,360	0.610600				
36.	Other Organ Acquisition	242,556	87,695	2.765905				
37.	Radio Mile Square	692,108	2,057,608	0.336365				
38.	Telemedicine Prgm	2,613,760	1,427,878	1.830521				
39.	Sleep Lab West Harr	1,779,803	5,296,239	0.336050		197,047		66,218
40.	Sickle Cell Clinic	2,172,523	4,578,391	0.474517		44,403		21,070
41.	Heart Ctr	141,916	616,448	0.230216		21,532		4,957
42.	Hyperbarid Oxygen Ther.	214,334	214,208	1.000588				
	Outpatient Service Cost Centers							
43.	Clinic	105,743,764	162,856,643	0.649306	4,366	8,307,510	2,835	5,394,116
44.	Emergency	20,790,145	82,765,913	0.251192	1,819,388	3,473,690	457,016	872,563
45.	Observation	14,263,179	20,640,849	0.691017	61,526	1,256,201	42,516	868,056
46.	**Total**				**61,001,439**	**46,923,618**	**14,562,638**	**14,529,680**

* 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: 07/01/2016 To: 06/30/2017

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)	135,175,088	21,373,132	6,180,195	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	72,548	12,060	3,431	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,863.25	1,772.23	1,801.28	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,093			
3.	Program general inpatient routine cost (Line 1c X Line 2)	9,489,532			
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)	9,489,532			

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	37,320,867	13,328	2,800.19	908	2,542,573
9.	Coronary Care Unit	18,761,330	5,694	3,294.93	344	1,133,456
10.	Pediatric ICU	8,584,240	1,711	5,017.09	519	2,603,870
11.	Neonatal ICU	24,226,958	10,363	2,337.83	1,044	2,440,695
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,918,315	3,810	765.96	289	221,362
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					14,562,638
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**32,994,126**

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: 07/01/2016 To: 06/30/2017

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: 07/01/2016 To: 06/30/2017

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.	Heart Ctr							
42.	Hyperbarid Oxygen Ther.							
	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: 07/01/2016 To: 06/30/2017

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: 07/01/2016 To: 06/30/2017

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		14,529,680
2.	Inpatient Operating Services (BHF Page 4, Line 25)	32,994,126	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	3,569,138	1,667,234
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**36,563,264**	**16,196,914**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	69.00%	31.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	61,001,439	46,923,618
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	12,508,232	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,591,644	
	F. Coronary Care Unit	1,598,547	
	G. Pediatric ICU	1,744,323	
	H. Neonatal ICU	6,130,837	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	432,438	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	88,007,460	46,923,618
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		82,170,900
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: 07/01/2016 To: 06/30/2017

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)	36,563,264	16,196,914
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	36,563,264	16,196,914
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)**	**36,563,264**	**16,196,914**

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.

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: 07/01/2016 To: 06/30/2017

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)	82,170,900
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:**
14-0150	**3098**
Program:	**Period Covered by Statement:**
Medicaid-Hospital	**From: 07/01/2016 To: 06/30/2017**

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: 07/01/2016 To: 06/30/2017

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	10,360,685	161,810,361	0.064030	4,665,346	4,342,629	298,722	278,059
2.	Recovery Room	114,603	13,739,724	0.008341	296,106	454,731	2,470	3,793
3.	Delivery and Labor Room	1,515,707	33,224,607	0.045620	2,225,879	539,293	101,545	24,603
4.	Anesthesiology	2,603,251	73,512,931	0.035412	2,658,182	1,891,467	94,132	66,981
5.	Radiology - Diagnostic	276,671	33,170,031	0.008341	673,032	857,957	5,614	7,156
6.	Radiology - Therapeutic	2,697,042	18,019,094	0.149677	163,681	907,307	24,499	135,803
7.	Nuclear Medicine	337,750	7,123,494	0.047414	89,289	142,863	4,234	6,774
8.	Laboratory	11,160,072	337,680,863	0.033049	9,370,258	10,651,906	309,678	352,035
9.	Blood							
10.	Blood - Administration	2,006,821	38,713,298	0.051838	2,106,854	652,213	109,215	33,809
11.	Intravenous Therapy	29,366	3,520,721	0.008341	217,098	6,920	1,811	58
12.	Respiratory Therapy	2,182,827	43,129,953	0.050610	3,653,807	184,542	184,919	9,340
13.	Physical Therapy	592,011	25,093,302	0.023592	452,987	511,418	10,687	12,065
14.	Occupational Therapy	268,695	8,021,159	0.033498	254,375	237,359	8,521	7,951
15.	Speech Pathology	212,376	2,103,237	0.100976	129,491	135,544	13,075	13,687
16.	EKG	612,419	5,015,833	0.122097	193,578	90,331	23,635	11,029
17.	EEG	69,457	8,327,159	0.008341	635,534	55,403	5,301	462
18.	Med. / Surg. Supplies	4,082,969	200,027,869	0.020412	7,676,319	3,176,079	156,689	64,830
19.	Drugs Charged to Patients	13,649,906	314,227,014	0.043440	11,904,314	2,140,994	517,123	93,005
20.	Renal Dialysis	1,809,717	36,096,391	0.050136	690,554	463,654	34,622	23,246
21.	Ambulance							
22.	Ultrasound	381,178	14,832,773	0.025698	454,501	412,989	11,680	10,613
23.	Radiology Angiography	2,616,299	65,900,729	0.039701	3,236,003	599,644	128,473	23,806
24.	Radiology W. Harrison	133,435	15,997,524	0.008341	5,251	440,922	44	3,678
25.	CT Scan	1,989,004	94,139,156	0.021128	2,894,502	1,920,564	61,155	40,578
26.	MRI	1,651,488	57,011,358	0.028968	1,552,585	1,732,622	44,975	50,191
27.	Cardiac Catheterization	2,685,283	18,277,664	0.146916	745,688	118,929	109,553	17,473
28.	Lab Tissue Typing	43,031	5,158,958	0.008341	32,992	70,335	275	587
29.	Lab Outreach	1,335,385	160,098,876	0.008341				
30.	Gastroenterology	233,707	28,019,090	0.008341	368,127	432,638	3,071	3,609
31.	Bone Marrow Transplant	25,904	3,105,667	0.008341	159,235	4,300	1,328	36
32.	Cardiac Services	282,455	33,863,478	0.008341	1,103,185	447,682	9,202	3,734
33.	Kidney Acquisition	426,631	11,105,664	0.038416	260,289		9,999	
34.	Liver Acquisition	332,308	3,134,170	0.106027	247,117		26,201	
35.	Pancreas Acquisition	8,044	964,360	0.008341				
36.	Other Organ Acquisition	70,314	87,695	0.801802				
37.	Radio Mile Square	17,163	2,057,608	0.008341				
38.	Telemedicine Prgm	11,910	1,427,878	0.008341				
39.	Sleep Lab West Harr	44,176	5,296,239	0.008341		197,047		1,644
40.	Sickle Cell Clinic	38,188	4,578,391	0.008341		44,403		370
41.	Heart Ctr	5,142	616,448	0.008341		21,532		180
42.	Hyperbarid Oxygen Ther.	1,787	214,208	0.008342				
	Outpatient Ancillary Centers							
43.	Clinic	4,941,923	162,856,643	0.030345	4,366	8,307,510	132	252,091
44.	Emergency	2,715,221	82,765,913	0.032806	1,819,388	3,473,690	59,687	113,958
45.	Observation							
46.	**Ancillary Total**						**2,372,267**	**1,667,234**

* 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: 07/01/2016 To: 06/30/2017

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	8,151,649	72,548	112.36	5,093		572,249	
48.	Psych	1,124,874	12,060	93.27				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,530,205	13,328	114.81	908		104,247	
52.	Coronary Care Unit	1,164,088	5,694	204.44	344		70,327	
53.	Pediatric ICU	654,833	1,711	382.72	519		198,632	
54.	Neonatal ICU	2,350,911	10,363	226.86	1,044		236,842	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	192,129	3,810	50.43	289		14,574	
67.	**Routine Total (lines 47-66)**						**1,196,871**	
68.	**Ancillary Total (from line 46)**						**2,372,267**	**1,667,234**
69.	**Total (Lines 67-68)**						**3,569,138**	**1,667,234**

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: 07/01/2016	To:	06/30/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,908		7,908
Newborn Days	289		289
Total Inpatient Revenue	88,007,460		88,007,460
Ancillary Revenue	61,001,439		61,001,439
Routine Revenue	27,006,021		27,006,021
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	146,056		146,056
Total Outpatient Revenue	46,923,618		46,923,618
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.