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)

[ ]	Medicaid Hospital	[ ]	Medicaid Sub II Rehab	[ ]	
[XXXX]	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								
2.	Psych				4,011			161	24.91
3.	Rehab								
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**				**4,011**	**3.48%**		**161**	**24.91**

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

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	11,134		3,108	
2.	Recovery Room	9,154,829	13,739,724	0.666304	10,508		7,002	
3.	Delivery and Labor Room	17,606,572	33,224,607	0.529926	24,859		13,173	
4.	Anesthesiology	4,135,253	73,512,931	0.056252	7,113		400	
5.	Radiology - Diagnostic	8,041,657	33,170,031	0.242437	17,260		4,184	
6.	Radiology - Therapeutic	8,923,156	18,019,094	0.495206				
7.	Nuclear Medicine	1,966,469	7,123,494	0.276054				
8.	Laboratory	44,613,682	337,680,863	0.132118	581,018		76,763	
9.	Blood							
10.	Blood - Administration	8,592,599	38,713,298	0.221955	3,479		772	
11.	Intravenous Therapy	630,214	3,520,721	0.179001	2,920		523	
12.	Respiratory Therapy	7,589,436	43,129,953	0.175967	29,448		5,182	
13.	Physical Therapy	12,286,630	25,093,302	0.489638	11,929		5,841	
14.	Occupational Therapy	4,328,953	8,021,159	0.539692	410,225		221,395	
15.	Speech Pathology	1,067,622	2,103,237	0.507609	3,002		1,524	
16.	EKG	536,495	5,015,833	0.106960	13,035		1,394	
17.	EEG	863,218	8,327,159	0.103663	11,783		1,221	
18.	Med. / Surg. Supplies	73,511,149	200,027,869	0.367505	190,829		70,131	
19.	Drugs Charged to Patients	88,070,313	314,227,014	0.280276	1,257,236		352,373	
20.	Renal Dialysis	10,454,849	36,096,391	0.289637				
21.	Ambulance							
22.	Ultrasound	2,650,637	14,832,773	0.178701	4,206		752	
23.	Radiology Angiography	7,290,104	65,900,729	0.110623				
24.	Radiology W. Harrison	2,810,006	15,997,524	0.175653				
25.	CT Scan	6,343,355	94,139,156	0.067383	32,483		2,189	
26.	MRI	6,105,513	57,011,358	0.107093	84,608		9,061	
27.	Cardiac Catheterization	2,517,604	18,277,664	0.137742				
28.	Lab Tissue Typing	1,791,411	5,158,958	0.347243				
29.	Lab Outreach	13,134,343	160,098,876	0.082039				
30.	Gastroenterology	6,274,832	28,019,090	0.223948	2,455		550	
31.	Bone Marrow Transplant	2,672,402	3,105,667	0.860492	45		39	
32.	Cardiac Services	5,649,124	33,863,478	0.166821	8,183		1,365	
33.	Kidney Acquisition	11,004,073	11,105,664	0.990852				
34.	Liver Acquisition	1,642,031	3,134,170	0.523913				
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				
40.	Sickle Cell Clinic	2,172,523	4,578,391	0.474517				
41.	Heart Ctr	141,916	616,448	0.230216				
42.	Hyperbarid Oxygen Ther.	214,334	214,208	1.000588				
	Outpatient Service Cost Centers							
43.	Clinic	105,743,764	162,856,643	0.649306				
44.	Emergency	20,790,145	82,765,913	0.251192	183,068		45,985	
45.	Observation	14,263,179	20,640,849	0.691017				
46.	**Total**				**2,900,826**		**824,927**	

* 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)		4,011		
3.	Program general inpatient routine cost (Line 1c X Line 2)		7,108,415		
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)		7,108,415		

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		
9.	Coronary Care Unit	18,761,330	5,694	3,294.93		
10.	Pediatric ICU	8,584,240	1,711	5,017.09		
11.	Neonatal ICU	24,226,958	10,363	2,337.83		
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		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					824,927
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**7,933,342**

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)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	7,933,342	
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)	481,197	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**8,414,539**	
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)	2,900,826	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	8,634,198	
	C. Rehab		
	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)**	11,535,024	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,120,485
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 (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	8,414,539	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	8,414,539	
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)**	**8,414,539**	

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: 07/01/2016 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)	3,120,485
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	11,134		713	
2.	Recovery Room	114,603	13,739,724	0.008341	10,508		88	
3.	Delivery and Labor Room	1,515,707	33,224,607	0.045620	24,859		1,134	
4.	Anesthesiology	2,603,251	73,512,931	0.035412	7,113		252	
5.	Radiology - Diagnostic	276,671	33,170,031	0.008341	17,260		144	
6.	Radiology - Therapeutic	2,697,042	18,019,094	0.149677				
7.	Nuclear Medicine	337,750	7,123,494	0.047414				
8.	Laboratory	11,160,072	337,680,863	0.033049	581,018		19,202	
9.	Blood							
10.	Blood - Administration	2,006,821	38,713,298	0.051838	3,479		180	
11.	Intravenous Therapy	29,366	3,520,721	0.008341	2,920		24	
12.	Respiratory Therapy	2,182,827	43,129,953	0.050610	29,448		1,490	
13.	Physical Therapy	592,011	25,093,302	0.023592	11,929		281	
14.	Occupational Therapy	268,695	8,021,159	0.033498	410,225		13,742	
15.	Speech Pathology	212,376	2,103,237	0.100976	3,002		303	
16.	EKG	612,419	5,015,833	0.122097	13,035		1,592	
17.	EEG	69,457	8,327,159	0.008341	11,783		98	
18.	Med. / Surg. Supplies	4,082,969	200,027,869	0.020412	190,829		3,895	
19.	Drugs Charged to Patients	13,649,906	314,227,014	0.043440	1,257,236		54,614	
20.	Renal Dialysis	1,809,717	36,096,391	0.050136				
21.	Ambulance							
22.	Ultrasound	381,178	14,832,773	0.025698	4,206		108	
23.	Radiology Angiography	2,616,299	65,900,729	0.039701				
24.	Radiology W. Harrison	133,435	15,997,524	0.008341				
25.	CT Scan	1,989,004	94,139,156	0.021128	32,483		686	
26.	MRI	1,651,488	57,011,358	0.028968	84,608		2,451	
27.	Cardiac Catheterization	2,685,283	18,277,664	0.146916				
28.	Lab Tissue Typing	43,031	5,158,958	0.008341				
29.	Lab Outreach	1,335,385	160,098,876	0.008341				
30.	Gastroenterology	233,707	28,019,090	0.008341	2,455		20	
31.	Bone Marrow Transplant	25,904	3,105,667	0.008341	45			
32.	Cardiac Services	282,455	33,863,478	0.008341	8,183		68	
33.	Kidney Acquisition	426,631	11,105,664	0.038416				
34.	Liver Acquisition	332,308	3,134,170	0.106027				
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				
40.	Sickle Cell Clinic	38,188	4,578,391	0.008341				
41.	Heart Ctr	5,142	616,448	0.008341				
42.	Hyperbarid Oxygen Ther.	1,787	214,208	0.008342				
	Outpatient Ancillary Centers							
43.	Clinic	4,941,923	162,856,643	0.030345				
44.	Emergency	2,715,221	82,765,913	0.032806	183,068		6,006	
45.	Observation							
46.	**Ancillary Total**						**107,091**	

* 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				
48.	Psych	1,124,874	12,060	93.27	4,011		374,106	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,530,205	13,328	114.81				
52.	Coronary Care Unit	1,164,088	5,694	204.44				
53.	Pediatric ICU	654,833	1,711	382.72				
54.	Neonatal ICU	2,350,911	10,363	226.86				
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				
67.	**Routine Total (lines 47-66)**						**374,106**	
68.	**Ancillary Total (from line 46)**						**107,091**	
69.	**Total (Lines 67-68)**						**481,197**	

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	4,011		4,011
Newborn Days			
Total Inpatient Revenue	11,535,024		11,535,024
Ancillary Revenue	2,900,826		2,900,826
Routine Revenue	8,634,198		8,634,198
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.