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:** 07/01/2017	**To:** 06/30/2018	

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 07/01/2017 and ending 06/30/2018 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: 07/01/2017 To: 06/30/2018

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	303	110,595		67,977	61.46%		19,291	5.08
2.	Psych	53	19,345		12,525	64.75%		974	12.86
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,330		13,342	87.03%			
6.	Coronary Care Unit	19	6,935		5,859	84.48%			
7.	Pediatric ICU	18	6,570		1,779	27.08%			
8.	Neonatal ICU	52	18,980		9,121	48.06%			
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				3,490				
22.	**Total**	**487**	**177,755**		**114,093**	**64.19%**		**20,265**	**5.46**
23.	Observation Bed Days				6,721				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,503			2,326	4.16
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				744				
6.	Coronary Care Unit				408				
7.	Pediatric ICU				384				
8.	Neonatal ICU				3,635				
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**				**9,674**	**8.48%**		**2,326**	**4.16**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	148,826	556,678

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: 07/01/2017 To: 06/30/2018

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	48,944,020	167,401,310	0.292375	4,379,386	4,507,015	1,280,423	1,317,739
2.	Recovery Room	10,307,711	13,762,347	0.748979	267,211	499,595	200,135	374,186
3.	Delivery and Labor Room	22,200,575	41,877,848	0.530127	6,029,423	711,205	3,196,360	377,029
4.	Anesthesiology	4,426,931	77,540,601	0.057092	2,863,840	1,982,515	163,502	113,186
5.	Radiology - Diagnostic	8,971,298	36,534,192	0.245559	941,708	883,116	231,245	216,857
6.	Radiology - Therapeutic	9,216,082	23,408,560	0.393706	128,562	1,172,344	50,616	461,559
7.	Nuclear Medicine	1,939,631	6,807,337	0.284932	72,460	205,429	20,646	58,533
8.	Laboratory	47,771,456	371,188,597	0.128699	12,383,637	10,928,931	1,593,762	1,406,542
9.	Blood							
10.	Blood - Administration	8,650,219	38,931,188	0.222193	3,117,784	706,602	692,750	157,002
11.	Intravenous Therapy	687,682	4,105,752	0.167492	244,264	17,624	40,912	2,952
12.	Respiratory Therapy	8,324,878	43,653,468	0.190704	6,921,092	186,258	1,319,880	35,520
13.	Physical Therapy	15,160,241	24,027,178	0.630962	805,110	532,002	507,994	335,673
14.	Occupational Therapy	5,074,098	8,211,007	0.617963	561,467	340,874	346,966	210,648
15.	Speech Pathology	1,158,594	1,959,417	0.591295	114,872	155,192	67,923	91,764
16.	EKG	569,873	5,109,320	0.111536	251,519	75,621	28,053	8,434
17.	EEG	1,068,669	9,397,506	0.113718	616,479	24,712	70,105	2,810
18.	Med. / Surg. Supplies	82,565,624	215,009,982	0.384008	7,951,573	3,880,060	3,053,468	1,489,974
19.	Drugs Charged to Patients	93,111,731	334,235,830	0.278581	13,984,882	2,313,180	3,895,922	644,408
20.	Renal Dialysis	11,694,349	35,747,822	0.327135	933,473	316,984	305,372	103,697
21.	Ambulance							
22.	Ultrasound	2,872,057	16,669,035	0.172299	706,961	396,225	121,809	68,269
23.	Radiology Angiography	7,030,611	62,086,036	0.113240	2,590,655	842,421	293,366	95,396
24.	Radiology W. Harrison	2,836,465	15,771,746	0.179845		457,387		82,259
25.	CT Scan	7,049,652	101,315,340	0.069581	3,100,202	1,950,786	215,715	135,738
26.	MRI	7,455,913	67,563,999	0.110353	1,351,944	1,894,521	149,191	209,066
27.	Cardiac Catheterization	2,991,310	22,146,595	0.135069	536,027	245,064	72,401	33,101
28.	Lab Tissue Typing	1,990,069	5,951,492	0.334382	41,104	117,208	13,744	39,192
29.	Lab Outreach	13,543,789	163,367,912	0.082904				
30.	Gastroenterology	7,364,086	34,240,612	0.215069	595,110	546,752	127,990	117,589
31.	Bone Marrow Transplant	3,176,441	4,799,763	0.661791	66,396	1,047	43,940	693
32.	Cardiac Services	6,226,061	32,969,661	0.188842	1,732,948	539,893	327,253	101,954
33.	Kidney Acquisition	11,109,357	12,845,250	0.864861	182,202		157,579	
34.	Liver Acquisition	2,813,042	5,189,452	0.542069	632,860		343,054	
35.	Pancreas Acquisition	1,080,980	1,898,580	0.569362				
36.	Other Organ Acquisition	246,768	184,160	1.339965				
37.	Radio Mile Square	729,821	2,221,301	0.328556		70,016		23,004
38.	Telemedicine Prgm	3,019,063	1,472,795	2.049887				
39.	Sleep Lab West Harr	2,099,575	5,777,751	0.363390		296,515		107,751
40.	Sickle Cell Clinic	2,465,060	4,955,416	0.497448		115,516		57,463
41.	Heart Ctr	188,705	556,729	0.338953		14,200		4,813
42.	Hyperbarid Oxygen Ther.	291,469	240,867	1.210083				
	Outpatient Service Cost Centers							
43.	Clinic	114,220,820	170,959,127	0.668118	16,709	8,671,816	11,164	5,793,796
44.	Emergency	25,257,600	93,524,980	0.270063	2,174,834	3,908,489	587,342	1,055,538
45.	Observation	13,984,116	18,984,643	0.736601	10,888	1,326,052	8,020	976,771
46.	**Total**				**76,307,582**	**50,833,167**	**19,538,602**	**16,310,906**

* 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: 07/01/2017 To: 06/30/2018

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)	155,420,815	22,911,201		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,698	12,525		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,080.66	1,829.24		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,503			
3.	Program general inpatient routine cost (Line 1c X Line 2)	9,369,212			
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)	9,369,212			

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	41,951,326	13,342	3,144.31	744	2,339,367
9.	Coronary Care Unit	21,663,054	5,859	3,697.40	408	1,508,539
10.	Pediatric ICU	9,225,851	1,779	5,185.98	384	1,991,416
11.	Neonatal ICU	23,991,709	9,121	2,630.38	3,635	9,561,431
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,958,549	3,490	847.72		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					19,538,602
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**44,308,567**

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: 07/01/2017 To: 06/30/2018

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: 07/01/2017 To: 06/30/2018

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: 07/01/2017 To: 06/30/2018

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: 07/01/2017 To: 06/30/2018

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		16,310,906
2.	Inpatient Operating Services (BHF Page 4, Line 25)	44,308,567	
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)	4,573,138	1,714,480
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**48,881,705**	**18,025,386**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	73.00%	27.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	76,307,582	50,833,167
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	12,728,261	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,500,589	
	F. Coronary Care Unit	2,518,957	
	G. Pediatric ICU	1,910,043	
	H. Neonatal ICU	23,797,737	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,258,079	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	123,021,248	50,833,167
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		106,947,324
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: 07/01/2017 To: 06/30/2018

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)	48,881,705	18,025,386
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	48,881,705	18,025,386
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)**	**48,881,705**	**18,025,386**

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: 07/01/2017 To: 06/30/2018

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)	106,947,324
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: 07/01/2017 To: 06/30/2018**

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: 07/01/2017 To: 06/30/2018

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	10,511,133	167,401,310	0.062790	4,379,386	4,507,015	274,982	282,995
2.	Recovery Room	111,489	13,762,347	0.008101	267,211	499,595	2,165	4,047
3.	Delivery and Labor Room	1,597,625	41,877,848	0.038150	6,029,423	711,205	230,022	27,132
4.	Anesthesiology	2,650,036	77,540,601	0.034176	2,863,840	1,982,515	97,875	67,754
5.	Radiology - Diagnostic	295,963	36,534,192	0.008101	941,708	883,116	7,629	7,154
6.	Radiology - Therapeutic	2,777,073	23,408,560	0.118635	128,562	1,172,344	15,252	139,081
7.	Nuclear Medicine	337,926	6,807,337	0.049641	72,460	205,429	3,597	10,198
8.	Laboratory	11,483,315	371,188,597	0.030937	12,383,637	10,928,931	383,113	338,108
9.	Blood							
10.	Blood - Administration	2,026,203	38,931,188	0.052046	3,117,784	706,602	162,268	36,776
11.	Intravenous Therapy	33,261	4,105,752	0.008101	244,264	17,624	1,979	143
12.	Respiratory Therapy	2,205,848	43,653,468	0.050531	6,921,092	186,258	349,730	9,412
13.	Physical Therapy	583,467	24,027,178	0.024284	805,110	532,002	19,551	12,919
14.	Occupational Therapy	271,533	8,211,007	0.033069	561,467	340,874	18,567	11,272
15.	Speech Pathology	213,819	1,959,417	0.109124	114,872	155,192	12,535	16,935
16.	EKG	621,091	5,109,320	0.121560	251,519	75,621	30,575	9,192
17.	EEG	76,129	9,397,506	0.008101	616,479	24,712	4,994	200
18.	Med. / Surg. Supplies	4,194,916	215,009,982	0.019510	7,951,573	3,880,060	155,135	75,700
19.	Drugs Charged to Patients	13,912,819	334,235,830	0.041626	13,984,882	2,313,180	582,135	96,288
20.	Renal Dialysis	1,773,506	35,747,822	0.049612	933,473	316,984	46,311	15,726
21.	Ambulance							
22.	Ultrasound	396,608	16,669,035	0.023793	706,961	396,225	16,821	9,427
23.	Radiology Angiography	2,602,603	62,086,036	0.041919	2,590,655	842,421	108,598	35,313
24.	Radiology W. Harrison	127,767	15,771,746	0.008101		457,387		3,705
25.	CT Scan	2,043,781	101,315,340	0.020172	3,100,202	1,950,786	62,537	39,351
26.	MRI	1,742,083	67,563,999	0.025784	1,351,944	1,894,521	34,859	48,848
27.	Cardiac Catheterization	2,752,711	22,146,595	0.124295	536,027	245,064	66,625	30,460
28.	Lab Tissue Typing	48,213	5,951,492	0.008101	41,104	117,208	333	950
29.	Lab Outreach	1,323,443	163,367,912	0.008101				
30.	Gastroenterology	277,383	34,240,612	0.008101	595,110	546,752	4,821	4,429
31.	Bone Marrow Transplant	38,883	4,799,763	0.008101	66,396	1,047	538	8
32.	Cardiac Services	267,087	32,969,661	0.008101	1,732,948	539,893	14,039	4,374
33.	Kidney Acquisition	443,395	12,845,250	0.034518	182,202		6,289	
34.	Liver Acquisition	353,098	5,189,452	0.068041	632,860		43,060	
35.	Pancreas Acquisition	15,380	1,898,580	0.008101				
36.	Other Organ Acquisition	72,187	184,160	0.391980				
37.	Radio Mile Square	17,995	2,221,301	0.008101		70,016		567
38.	Telemedicine Prgm	11,931	1,472,795	0.008101				
39.	Sleep Lab West Harr	46,806	5,777,751	0.008101		296,515		2,402
40.	Sickle Cell Clinic	40,144	4,955,416	0.008101		115,516		936
41.	Heart Ctr	4,510	556,729	0.008101		14,200		115
42.	Hyperbarid Oxygen Ther.	1,951	240,867	0.008100				
	Outpatient Ancillary Centers							
43.	Clinic	5,025,737	170,959,127	0.029397	16,709	8,671,816	491	254,925
44.	Emergency	2,814,873	93,524,980	0.030098	2,174,834	3,908,489	65,458	117,638
45.	Observation							
46.	**Ancillary Total**						**2,822,884**	**1,714,480**

* 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: 07/01/2017 To: 06/30/2018

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	8,332,174	74,698	111.54	4,503		502,265	
48.	Psych	1,155,621	12,525	92.27				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,556,659	13,342	116.67	744		86,802	
52.	Coronary Care Unit	1,188,796	5,859	202.90	408		82,783	
53.	Pediatric ICU	666,073	1,779	374.41	384		143,773	
54.	Neonatal ICU	2,345,206	9,121	257.12	3,635		934,631	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	192,177	3,490	55.07				
67.	**Routine Total (lines 47-66)**						**1,750,254**	
68.	**Ancillary Total (from line 46)**						**2,822,884**	**1,714,480**
69.	**Total (Lines 67-68)**						**4,573,138**	**1,714,480**

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: 07/01/2017 To: 06/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	9,674		9,674
Newborn Days			
Total Inpatient Revenue	123,021,248		123,021,248
Ancillary Revenue	76,307,582		76,307,582
Routine Revenue	46,713,666		46,713,666
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	148,826		148,826
Total Outpatient Revenue	50,833,167		50,833,167
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.

BHF Page 9 - included Psych amt in 10b in A&P total on 10a