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:		Medicare Provider Number:
University of Wisconsin Hospitals and Clinics		52-0098
Street:		**Medicaid Provider Number:**
600 Highland Avenue		13031
City:	**State:**	**Zip:**
Madison	Wisconsin	53792
Period Covered by Statement:	**From:**	**To:**
	07/01/2018	06/30/2019

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 Wisconsin Hospitals 13031 for the cost report beginning 07/01/2018 and ending 06/30/2019 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.

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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	498	181,770		139,195	76.58%		32,219	5.24
2.	Psych	18	6,570		5,241	79.77%		1,282	4.09
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,980	91.10%			
8.	Cardio Surgery ICU	7	2,555		2,338	91.51%			
9.	Cardiac ICU	7	2,555		2,095	82.00%			
10.	Pediatric ICU	21	7,665		4,103	53.53%			
11.	Neuro ICU	18	6,570		6,054	92.15%			
12.	Neonatal ICU	26	9,490		4,857	51.18%			
13.	Burn ICU	7	2,555		2,308	90.33%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**	**626**	**228,490**		**174,171**	**76.23%**		**33,501**	**5.20**
23.	Observation Bed Days				6,845				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				322			60	7.50
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				80				
8.	Cardio Surgery ICU				9				
9.	Cardiac ICU				1				
10.	Pediatric ICU				26				
11.	Neuro ICU				12				
12.	Neonatal ICU								
13.	Burn ICU								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**450**	**0.26%**		**60**	**7.50**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	741	1,199,736

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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	141,531,613	729,208,421	0.194089	1,105,274	401,622	214,522	77,950
2.	Recovery Room	24,484,735	78,791,909	0.310752	50,900	116,652	15,817	36,250
3.	Delivery and Labor Room							
4.	Anesthesiology	15,698,447	58,830,090	0.266844	78,714	54,552	21,004	14,557
5.	Radiology - Diagnostic	53,280,203	222,551,885	0.239406	185,711	106,532	44,460	25,504
6.	Radiology - Therapeutic	18,882,979	140,284,096	0.134605		115,724		15,577
7.	Nuclear Medicine	12,048,728	32,286,462	0.373182		17,421		6,501
8.	Laboratory	57,924,761	367,750,192	0.157511	453,232	158,805	71,389	25,014
9.	Blood							
10.	Blood - Administration	15,420,462	53,619,099	0.287593	74,300	28,460	21,368	8,185
11.	Intravenous Therapy							
12.	Respiratory Therapy	32,281,999	127,864,014	0.252471	550,643	10,556	139,021	2,665
13.	Physical Therapy	30,782,941	94,171,836	0.326881	98,903	16,323	32,330	5,336
14.	Occupational Therapy							
15.	Speech Pathology	4,904,883	6,641,631	0.738506	5,067	8,259	3,742	6,099
16.	EKG	32,632,215	213,385,443	0.152926	387,660	101,439	59,283	15,513
17.	EEG	5,785,735	25,399,698	0.227788	30,687	37,746	6,990	8,598
18.	Med. / Surg. Supplies	1,534,434	2,726,820	0.562719	76,470	408	43,031	230
19.	Drugs Charged to Patients	184,240,249	742,186,742	0.248240	914,279	222,803	226,961	55,309
20.	Renal Dialysis	4,227,459	11,842,509	0.356973	56,880		20,305	
21.	Ambulance	13,495,480	17,630,237	0.765474	82,790		63,374	
22.	CT Scan	10,007,015	224,073,977	0.044659	224,920	79,694	10,045	3,559
23.	MRI	14,419,954	170,843,596	0.084404	60,744	125,177	5,127	10,565
24.	Cardiac Rehab	1,610,462	4,025,004	0.400114				
25.	Neuropsych Testing	1,100,275	1,590,849	0.691628				
26.	Clinic-CSC	92,181,599	134,733,084	0.684179	21,019	121,063	14,381	82,829
27.	Clinic-University Station	14,399,544	21,259,173	0.677333	1,560	8,173	1,057	5,536
28.	Clinic-Waisman	3,632,087	2,386,127	1.522168	510	17,169	776	26,134
29.	Clinic-West	21,939,600	41,188,307	0.532666		6,225		3,316
30.	Clinic-East	10,176,286	18,508,955	0.549803		4,093		2,250
31.	Clinic-Research Park	4,237,399	6,047,922	0.700637		1,454		1,019
32.	Pulmonary Function	1,320,458	5,793,042	0.227939	4,624	13,324	1,054	3,037
33.	Orthotics	3,678,663	8,178,994	0.449770	4,945	4,735	2,224	2,130
34.	Implantable Devices	71,210,010	90,255,050	0.788986	110,614	19,119	87,273	15,085
35.	Clinic-DHC	20,537,480	82,997,835	0.247446		5,502		1,361
36.	Clinic -The American Ctr	12,505,817	20,833,990	0.600260		1,918		1,151
37.	Clinic-Oakwood Village	36,348	57,731	0.629610				
38.	Clinic-Middleton Rehab	621,588	2,151,599	0.288896		2,665		770
39.	Clinic-Aoda	229,548	186,550	1.230490				
40.	Clinic-Kidney	923,018	888,477	1.038877		389		404
41.	Clinic-Pain Management	3,266,683	5,204,727	0.627638				
42.	Clinic Women's Wellness/Pelvic Surgery	1,152,458	2,003,864	0.575118				
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	40,864,659	213,568,642	0.191342	131,822	50,547	25,223	9,672
45.	Observation	9,057,578	44,169,043	0.205066				
46.	**Total**				**4,712,268**	**1,858,549**	**1,130,757**	**472,106**

* 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 BHF Page 4

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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)	193,245,737	5,583,841		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	146,040	5,241		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,323.24	1,065.42		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	322			
3.	Program general inpatient routine cost (Line 1c X Line 2)	426,083			
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)	426,083			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit					
9.	Coronary Care Unit					
10.	Trauma ICU	20,601,259	7,980	2,581.61	80	206,529
11.	Cardio Surgery ICU	8,346,717	2,338	3,570.02	9	32,130
12.	Cardiac ICU	4,930,947	2,095	2,353.67	1	2,354
13.	Pediatric ICU	11,154,422	4,103	2,718.60	26	70,684
14.	Neuro ICU	14,130,866	6,054	2,334.14	12	28,010
15.	Neonatal ICU	10,846,366	4,857	2,233.14		
16.	Burn ICU	6,246,256	2,308	2,706.35		
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,130,757
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,896,547**

Hospital Statement of Cost

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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

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

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense **BHF Page 6(a)**

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Neonatal ICU							
59.	Burn ICU							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

Hospital Statement of Cost BHF Page 7

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		472,106
2.	Inpatient Operating Services (BHF Page 4, Line 25)	1,896,547	
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)	145,773	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**2,042,320**	**472,106**
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	81.00%	19.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	4,712,268	1,858,549
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,002,632	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU		
	H. Cardio Surgery ICU	46,980	
	I. Cardiac ICU	8,470	
	J. Pediatric ICU	216,461	
	K. Neuro ICU	96,775	
	L. Neonatal ICU		
	M. Burn ICU	755,142	
	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)**	6,838,728	1,858,549
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,182,851
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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)	2,042,320	472,106
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,042,320	472,106
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)**	**2,042,320**	**472,106**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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)	6,182,851
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:**
52-0098	**13031**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 07/01/2018 To: 06/30/2019**

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

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

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

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense **BHF Supplement No. 2(a)**

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Rehab							
25.	Neuropsych Testing							
26.	Clinic-CSC							
27.	Clinic-University Station							
28.	Clinic-Waisman							
29.	Clinic-West							
30.	Clinic-East							
31.	Clinic-Research Park							
32.	Pulmonary Function							
33.	Orthotics							
34.	Implantable Devices							
35.	Clinic-DHC							
36.	Clinic -The American Ctr							
37.	Clinic-Oakwood Village							
38.	Clinic-Middleton Rehab							
39.	Clinic-Aoda							
40.	Clinic-Kidney							
41.	Clinic-Pain Management							
42.	Clinic Women's Wellness/Pelvic Surgery							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	**Ancillary Total**							

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

Hospital Statement of Cost / Graduate Medical Education Expense **BHF Supplement No. 2(b)**

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

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	66,113,074	146,040	452.71	322		145,773	
48.	Psych	500,772	5,241	95.55				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Trauma ICU							
54.	Cardio Surgery ICU							
55.	Cardiac ICU							
56.	Pediatric ICU							
57.	Neuro ICU							
58.	Neonatal ICU							
59.	Burn ICU							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**						**145,773**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**145,773**	

Hospital Statement of Cost

Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
52-0098	13031
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	450		450
Newborn Days			
Total Inpatient Revenue	6,838,988	(260)	6,838,728
Ancillary Revenue	4,712,528	(260)	4,712,268
Routine Revenue	2,126,460		2,126,460
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	741		741
Total Outpatient Revenue	1,858,677	(128)	1,858,549
Outpatient Received and Receivable			

Notes:

BHF Page 2 -Included Obervation Days per W/S S-3

BHF Page 2 - Psych Program Inpatient Days totaling 2 is included with Adults and Peds

BHF Page 3 - Moved Clinic Women's Wellness/Pelvic Surgery from line 43 Clinic to line 42 in Ancilliary Service Cost Centers

BHF Page 3 - Removed Home Health Agency Costs and Charges

BHF Page 3 - Removed Cardiac Rehab. I/P ($260) charges and O/P ($130) charges since they are not covered by IL Medicaid.

BHF Page 7 - Psych Customary Charges of $4,492 included with Adults and Peds

BHF Page 7 - Reclassed ICU Customary Charges to Burn ICU as that had 21 Program Days

$2.00 minor difference on outpatient revenue (charges) is due to the rounding.