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:** 07/01/2018	**To:** 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)

[ ]	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 07/01/2018 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.

Hospital Statement of Cost / Statistical Data

PRELIMINARY

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 07/01/2018 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	303	110,595		70,159	63.44%		19,417	5.11
2.	Psych	50	18,250		13,012	71.30%		1,011	12.87
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,330		13,139	85.71%			
6.	Coronary Care Unit	19	6,935		5,688	82.02%			
7.	Pediatric ICU	18	6,570		1,687	25.68%			
8.	Neonatal ICU	52	18,980		8,629	45.46%			
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				3,360				
22.	**Total**	**484**	**176,660**		**115,674**	**65.48%**		**20,428**	**5.50**
23.	Observation Bed Days				7,270				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				3,918			162	24.19
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**				**3,918**	**3.39%**		**162**	**24.19**

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		573,114

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: 07/01/2018 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	43,502,317	189,396,510	0.229689	24,533		5,635	
2.	Recovery Room	8,773,573	14,733,497	0.595485	9,810		5,842	
3.	Delivery and Labor Room	19,673,599	45,727,143	0.430239	9,117		3,922	
4.	Anesthesiology	3,617,578	84,956,061	0.042582	12,072		514	
5.	Radiology - Diagnostic	12,178,725	38,464,578	0.316622	15,691		4,968	
6.	Radiology - Therapeutic	7,880,357	25,813,854	0.305276				
7.	Nuclear Medicine	1,794,850	7,374,093	0.243399	2,270		553	
8.	Laboratory	44,633,359	406,717,506	0.109740	517,145		56,751	
9.	Blood							
10.	Blood - Administration	8,569,188	39,941,059	0.214546	6,693		1,436	
11.	Intravenous Therapy	855,491	5,416,345	0.157946	1,741		275	
12.	Respiratory Therapy	7,149,237	47,030,185	0.152014	19,930		3,030	
13.	Physical Therapy	13,625,076	25,403,489	0.536347	4,582		2,458	
14.	Occupational Therapy	5,145,205	9,027,713	0.569934	553,621		315,527	
15.	Speech Pathology	970,877	2,062,460	0.470737	653		307	
16.	EKG	497,213	5,429,773	0.091572	18,032		1,651	
17.	EEG	1,167,635	6,021,016	0.193927	5,244		1,017	
18.	Med. / Surg. Supplies	87,508,121	200,688,721	0.436039	80,151		34,949	
19.	Drugs Charged to Patients	100,312,057	361,166,670	0.277745	989,891		274,937	
20.	Renal Dialysis	10,220,462	35,451,343	0.288295				
21.	Ambulance							
22.	Ultrasound	2,684,597	18,705,414	0.143520	6,111		877	
23.	Radiology Angiography	4,999,237	63,139,381	0.079178				
24.	Radiology W. Harrison	2,933,137	16,154,373	0.181569				
25.	CT Scan	5,349,365	116,968,359	0.045733	56,788		2,597	
26.	MRI	5,195,700	73,611,842	0.070582	69,472		4,903	
27.	Cardiac Catheterization	2,689,832	25,592,589	0.105102				
28.	Lab Tissue Typing	2,052,294	7,185,591	0.285612				
29.	Lab Outreach	12,132,864	175,016,898	0.069324				
30.	Gastroenterology	7,402,388	39,027,446	0.189671	3,781		717	
31.	Bone Marrow Transplant	2,818,869	3,698,620	0.762141				
32.	Cardiac Services	6,284,330	35,752,820	0.175772	5,956		1,047	
33.	Kidney Acquisition	12,944,857	21,044,320	0.615124				
34.	Liver Acquisition	3,660,676	7,309,555	0.500807				
35.	Pancreas Acquisition	1,232,468	2,658,020	0.463679				
36.	Other Organ Acquisition	221,371	96,684	2.289634				
37.	Radio Mile Square	854,183	2,578,635	0.331254				
38.	Telemedicine Prgm	2,151,284	1,594,818	1.348921				
39.	Sleep Lab West Harr	1,992,802	7,396,027	0.269442				
40.	Sickle Cell Clinic	2,017,530	6,271,098	0.321719				
41.	Heart Ctr	400,607	737,314	0.543333				
42.	Hyperbarid Oxygen Ther.	227,536	205,920	1.104973				
	Outpatient Service Cost Centers							
43.	Clinic	105,075,382	182,153,955	0.576849	490		283	
44.	Emergency	22,326,984	112,267,003	0.198874	266,894		53,078	
45.	Observation	12,603,708	22,660,444	0.556199				
46.	**Total**				**2,680,668**		**777,274**	

* 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: 07/01/2018 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)	134,235,820	20,205,150		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	77,429	13,012		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,733.66	1,552.81		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		3,918		
3.	Program general inpatient routine cost (Line 1c X Line 2)		6,083,910		
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)		6,083,910		

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	35,300,642	13,139	2,686.71		
9.	Coronary Care Unit	17,982,078	5,688	3,161.41		
10.	Pediatric ICU	7,332,936	1,687	4,346.73		
11.	Neonatal ICU	20,332,671	8,629	2,356.32		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,648,945	3,360	788.38		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					777,274
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**6,861,184**

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: 07/01/2018 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.	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: 07/01/2018 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.	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: 07/01/2018 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.	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: 07/01/2018 To: 06/30/2019

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	6,861,184	
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)	395,662	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**7,256,846**	
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)	2,680,668	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	9,405,207	
	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)**	12,085,875	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		4,829,029
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: 07/01/2018 To: 06/30/2019

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)	7,256,846	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	7,256,846	
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)**	**7,256,846**	

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: 07/01/2018 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)	4,829,029
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: 07/01/2018 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:
14-0150	3098
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	9,464,759	189,396,510	0.049973	24,533		1,226	
2.	Recovery Room	117,971	14,733,497	0.008007	9,810		79	
3.	Delivery and Labor Room	1,458,639	45,727,143	0.031899	9,117		291	
4.	Anesthesiology	2,435,612	84,956,061	0.028669	12,072		346	
5.	Radiology - Diagnostic	307,986	38,464,578	0.008007	15,691		126	
6.	Radiology - Therapeutic	2,453,073	25,813,854	0.095029				
7.	Nuclear Medicine	304,550	7,374,093	0.041300	2,270		94	
8.	Laboratory	10,615,505	406,717,506	0.026100	517,145		13,497	
9.	Blood							
10.	Blood - Administration	1,805,120	39,941,059	0.045195	6,693		302	
11.	Intravenous Therapy	43,369	5,416,345	0.008007	1,741		14	
12.	Respiratory Therapy	1,984,636	47,030,185	0.042199	19,930		841	
13.	Physical Therapy	540,977	25,403,489	0.021295	4,582		98	
14.	Occupational Therapy	250,276	9,027,713	0.027723	553,621		15,348	
15.	Speech Pathology	188,368	2,062,460	0.091332	653		60	
16.	EKG	546,764	5,429,773	0.100697	18,032		1,816	
17.	EEG	48,210	6,021,016	0.008007	5,244		42	
18.	Med. / Surg. Supplies	3,736,681	200,688,721	0.018619	80,151		1,492	
19.	Drugs Charged to Patients	12,620,041	361,166,670	0.034942	989,891		34,589	
20.	Renal Dialysis	1,550,888	35,451,343	0.043747				
21.	Ambulance							
22.	Ultrasound	376,867	18,705,414	0.020147	6,111		123	
23.	Radiology Angiography	2,328,440	63,139,381	0.036878				
24.	Radiology W. Harrison	129,348	16,154,373	0.008007				
25.	CT Scan	1,998,380	116,968,359	0.017085	56,788		970	
26.	MRI	1,626,673	73,611,842	0.022098	69,472		1,535	
27.	Cardiac Catheterization	2,439,026	25,592,589	0.095302				
28.	Lab Tissue Typing	57,535	7,185,591	0.008007				
29.	Lab Outreach	1,401,360	175,016,898	0.008007				
30.	Gastroenterology	312,493	39,027,446	0.008007	3,781		30	
31.	Bone Marrow Transplant	29,615	3,698,620	0.008007				
32.	Cardiac Services	286,273	35,752,820	0.008007	5,956		48	
33.	Kidney Acquisition	463,109	21,044,320	0.022006				
34.	Liver Acquisition	328,585	7,309,555	0.044953				
35.	Pancreas Acquisition	21,283	2,658,020	0.008007				
36.	Other Organ Acquisition	62,151	96,684	0.642826				
37.	Radio Mile Square	20,647	2,578,635	0.008007				
38.	Telemedicine Prgm	12,770	1,594,818	0.008007				
39.	Sleep Lab West Harr	59,220	7,396,027	0.008007				
40.	Sickle Cell Clinic	50,213	6,271,098	0.008007				
41.	Heart Ctr	5,904	737,314	0.008007				
42.	Hyperbarid Oxygen Ther.	1,649	205,920	0.008008				
	Outpatient Ancillary Centers							
43.	Clinic	4,619,398	182,153,955	0.025360	490		12	
44.	Emergency	2,684,979	112,267,003	0.023916	266,894		6,383	
45.	Observation							
46.	**Ancillary Total**						**79,362**	

* 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: 07/01/2018 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	7,554,835	77,429	97.57				
48.	Psych	1,050,460	13,012	80.73	3,918		316,300	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,422,916	13,139	108.30				
52.	Coronary Care Unit	1,066,230	5,688	187.45				
53.	Pediatric ICU	582,977	1,687	345.57				
54.	Neonatal ICU	2,074,933	8,629	240.46				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	171,775	3,360	51.12				
67.	**Routine Total (lines 47-66)**						**316,300**	
68.	**Ancillary Total (from line 46)**						**79,362**	
69.	**Total (Lines 67-68)**						**395,662**	

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: 07/01/2018 To: 06/30/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,918		3,918
Newborn Days			
Total Inpatient Revenue	12,085,875		12,085,875
Ancillary Revenue	2,680,668		2,680,668
Routine Revenue	9,405,207		9,405,207
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2, Part II, Col 7 - Changed Acute Discharges to agree with Medicare W/S S-3 col 14. Provider included Psych discharges in their total

Reclassified Blood charges as Blood Admin.

BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1. Provider combined W/S Col 1 amts with W/S B, Part 1, Col 25 amts

GME Costs were adjusted to filed W/S B, Pt 1, Col 25.

BHF Page 3 -Clinic costs and charges include Medicare lines 90, 93.01, 93.02, 93.03, and 93.04.

BHF Page 3 - Physical Therapy costs and charges include Medicare lines 66, 66.01, 66.02, 66.03

BHF Page 3 - Occupational Therapy costs and charges include Medicare lines 67 and 67.01