

Hospital Statement of Cost

BHF Page 1

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information Preliminary

Name of Hospital: University of Wisconsin Hospitals and Clinics		Medicare Provider Number: 52-0098	
Street: 600 Highland Avenue		Medicaid Provider Number: 13031	
City: Madison	State: Wisconsin	Zip: 53792	
Period Covered by Statement:	From: 07/01/2015	To: 06/30/2016	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ Other (Specify) _____	☐ Corporation	☐ County	☐ Other (Specify) _____

Type of Hospital

☐ 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	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ U of I - Division of Specialized Care for Children

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 Hospi 13031 for the cost report beginning 07/01/2015 and ending 06/30/2016 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):

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

Name (Typewritten)

Title	Date
Firm	
Telephone Number	
Email Address	

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

BHF Page 2

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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	468	171,288		126,352	73.77%		30,819	4.99
2.	Psych	18	6,588		5,536	84.03%		1,298	4.27
3.	Rehab	21	2,709		1,841	67.96%		159	11.58
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,784		8,045	91.59%			
8.	Cardio Surgery ICU	7	2,562		1,898	74.08%			
9.	Cardiac ICU	7	2,562		2,046	79.86%			
10.	Pediatric ICU	21	7,686		4,141	53.88%			
11.	Neuro ICU	16	5,856		5,422	92.59%			
12.	Neonatal ICU	14	5,124		3,585	69.96%			
13.	Burn ICU	7	2,562		2,244	87.59%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	603	215,721		161,110	74.68%		32,276	4.99
23.	Observation Bed Days				5,791				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				517			86	7.50
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				73				
8.	Cardio Surgery ICU				5				
9.	Cardiac ICU								
10.	Pediatric ICU				45				
11.	Neuro ICU				2				
12.	Neonatal ICU								
13.	Burn ICU				3				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				645	0.40%		86	7.50

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	834	1,098,331

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

BHF Page 3

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	111,176,457	548,765,887	0.202594	1,246,048	329,009	252,442	66,655
2.	Recovery Room	22,176,124	65,188,644	0.340184	97,042	68,978	33,012	23,465
3.	Delivery and Labor Room							
4.	Anesthesiology	13,548,044	42,672,767	0.317487	70,200	38,836	22,288	12,330
5.	Radiology - Diagnostic	46,793,850	166,425,860	0.281169	237,784	46,666	66,857	13,121
6.	Radiology - Therapeutic	15,287,659	98,535,664	0.155148	15,852	113,198	2,459	17,562
7.	Nuclear Medicine	6,698,711	24,462,981	0.273831	17,857	34,299	4,890	9,392
8.	Laboratory	52,223,394	323,911,503	0.161227	450,791	182,773	72,680	29,468
9.	Blood							
10.	Blood - Administration	13,943,806	43,186,367	0.322875	64,510	57,189	20,829	18,465
11.	Intravenous Therapy							
12.	Respiratory Therapy	30,326,376	76,592,198	0.395946	266,966	19,524	105,704	7,730
13.	Physical Therapy	30,435,147	79,818,765	0.381303	127,471	12,779	48,605	4,873
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	39,580,135	187,722,398	0.210844	44,170	119,224	9,313	25,138
17.	EEG	4,131,513	16,437,506	0.251347	12,699	13,821	3,192	3,474
18.	Med. / Surg. Supplies	2,179,234	3,258,399	0.668805	11,563	486	7,733	325
19.	Drugs Charged to Patients	185,828,363	531,468,145	0.349651	1,215,835	124,688	425,118	43,597
20.	Renal Dialysis	4,764,996	10,458,086	0.455628	38,961		17,752	
21.	Ambulance	8,324,912	18,556,240	0.448631	93,561		41,974	
22.	CT Scan	12,894,281	202,535,281	0.063664	184,518	196,530	11,747	12,512
23.	MRI	11,610,229	130,097,505	0.089243	44,937	106,695	4,010	9,522
24.	Cardiac Rehab	1,561,035	2,983,947	0.523144				
25.	Neuropsych Testing	1,035,590	1,999,695	0.517874		1,977		1,024
26.	Clinic-CSC	89,330,499	133,077,203	0.671268	52,228	258,500	35,059	173,523
27.	Clinic-University Station	15,569,402	21,777,413	0.714933	131	18,703	94	13,371
28.	Clinic-Waisman	3,073,808	2,454,711	1.252208		22,491		28,163
29.	Clinic-West	24,427,303	37,367,269	0.653709	1,829	6,850	1,196	4,478
30.	Clinic-East	11,664,886	18,968,928	0.614947		5,625		3,459
31.	Clinic-Research Park	3,722,538	5,427,066	0.685921		891		611
32.	Pulmonary Function	1,071,118	4,458,378	0.240248	7,045	11,610	1,693	2,789
33.	Orthotics	2,703,258	5,268,982	0.513051	787		404	
34.	Implantable Devices	58,017,481	63,611,620	0.912058				
35.	Clinic-DHC	19,897,110	55,664,560	0.357447		3,990		1,426
36.	Clinic -The American Ctr	8,657,569	12,711,793	0.681066		4,724		3,217
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	32,406,259	124,244,207	0.260827	37,333	56,003	9,737	14,607
45.	Observation	7,564,320	28,675,035	0.263795		88,703		23,399
46.	Total				4,340,118	1,944,762	1,198,788	567,696

* 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: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	172,607,738	5,604,715	2,349,212	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	132,143	5,536	1,841	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,306.22	1,012.41	1,276.05	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	517			
3.	Program general inpatient routine cost (Line 1c X Line 2)	675,316			
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)	675,316			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit					
9.	Coronary Care Unit					
10.	Trauma ICU	20,720,786	8,045	2,575.61	73	188,020
11.	Cardio Surgery ICU	5,850,328	1,898	3,082.36	5	15,412
12.	Cardiac ICU	4,779,234	2,046	2,335.89		
13.	Pediatric ICU	12,620,645	4,141	3,047.73	45	137,148
14.	Neuro ICU	13,207,960	5,422	2,435.99	2	4,872
15.	Neonatal ICU	8,525,436	3,585	2,378.09		
16.	Burn ICU	5,650,579	2,244	2,518.08	3	7,554
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)					1,198,788
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,227,110

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

Preliminary

Medicare Provider Number:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (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)	
		(1)	(2)	(3)	(4)	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:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	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:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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
Computation of Lesser of Reasonable Cost or Customary Charges**

BHF Page 7

Preliminary

Medicare Provider Number: 52-0098		Medicaid Provider Number: 13031	
Program: Medicaid Hospital		Period Covered by Statement: From: 07/01/2015 To: 06/30/2016	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		567,696
2.	Inpatient Operating Services (BHF Page 4, Line 25)	2,227,110	
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)	171,318	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,398,428	567,696
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)	4,340,118	1,944,762
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,493,125	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU	401,914	
	H. Cardio Surgery ICU	7,746	
	I. Cardiac ICU		
	J. Pediatric ICU	338,774	
	K. Neuro ICU	14,388	
	L. Neonatal ICU		
	M. Burn ICU	17,663	
	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)	6,613,728	1,944,762
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		5,592,366
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

BHF Page 8

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	2,398,428	567,696
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,398,428	567,696
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)	2,398,428	567,696

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

BHF Page 9

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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)	5,592,366
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)	(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

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

1. Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	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:	52-0098	Medicaid Provider Number:	13031
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2015 To: 06/30/2016

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	43,787,792	132,143	331.37	517		171,318	
48.	Psych	249,608	5,536	45.09				
49.	Rehab	73,655	1,841	40.01				
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)						171,318	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						171,318	

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2015 To: 06/30/2016

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	645		645
Newborn Days			
Total Inpatient Revenue	6,613,927	(199)	6,613,728
Ancillary Revenue	4,340,317	(199)	4,340,118
Routine Revenue	2,273,610		2,273,610
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	834		834
Total Outpatient Revenue	1,946,310	(1,548)	1,944,762
Outpatient Received and Receivable			

Notes:

BHF P.3 - Removed Cardiac Rehab. I/P (\$200) charges and \$1,548 O/P charges since they are not covered by IL Medicaid.

BHF Page 2 - Included 3 Medicaid filed Psych days and 8 Rehab days with Adults and Peds.

BHF Page 7 - Included \$5,724 Psych charges and \$15,264 Rehab charges with Adults & Peds charges.

\$1.00 adjustment is due to the rounding error.