

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 Chicago Medical Center		Medicare Provider Number: 14-0088
Street: 5841 South Maryland Avenue		Medicaid Provider Number: 3023
City: Chicago	State: Illinois	Zip: 60637-1424
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 Chicago Medica 3023 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:	14-0088	Medicaid Provider Number:	3023
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	384	140,544		115,207	81.97%		23,864	5.82
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	66	22,742		19,654	86.42%			
6.	Coronary Care Unit	9	3,294		2,564	77.84%			
7.	Burn ICU	5	1,830		1,542	84.26%			
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,954		2,800	40.26%			
22.	Total	483	175,364		141,767	80.84%		23,864	5.82
23.	Observation Bed Days				7,322				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				14,458			3,118	5.55
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				2,075				
6.	Coronary Care Unit				510				
7.	Burn ICU				277				
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				515				
22.	Total				17,835	12.58%		3,118	5.55

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

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

BHF Page 3

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
14-0088		3023	
Program:		Period Covered by Statement:	
Medicaid Hospital		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	131,976,378	520,010,789	0.253795	20,924,158		5,310,447	
2.	Recovery Room							
3.	Delivery and Labor Room	10,187,427	26,733,027	0.381080	4,988,991		1,901,205	
4.	Anesthesiology	17,708,300	184,078,756	0.096200	7,379,878		709,944	
5.	Radiology - Diagnostic	50,073,411	219,281,602	0.228352	9,592,395		2,190,443	
6.	Radiology - Therapeutic	16,996,581	132,905,744	0.127884	1,782,146		227,908	
7.	Nuclear Medicine							
8.	Laboratory	56,622,435	663,558,543	0.085331	33,550,999		2,862,940	
9.	Blood							
10.	Blood - Administration	17,273,223	122,278,030	0.141262	8,773,051		1,239,299	
11.	Intravenous Therapy							
12.	Respiratory Therapy	18,294,576	142,036,314	0.128802	11,223,909		1,445,662	
13.	Physical Therapy	10,585,350	40,444,233	0.261727	2,051,136		536,838	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	29,197,190	145,173,958	0.201119	9,672,058		1,945,235	
17.	EEG	5,761,731	35,623,953	0.161738	1,346,902		217,845	
18.	Med. / Surg. Supplies	27,339,026	112,807,773	0.242351	5,512,367		1,335,928	
19.	Drugs Charged to Patients	167,650,817	958,561,221	0.174898	34,383,525		6,013,610	
20.	Renal Dialysis	5,352,453	27,455,555	0.194950	3,113,310		606,940	
21.	Ambulance	1,222,228	6,870	177.908006				
22.	CT Scan	7,243,189	281,738,350	0.025709	10,330,945		265,598	
23.	MRI	7,555,691	126,801,418	0.059587	3,699,498		220,442	
24.	Cardiac Cath	8,214,163	92,074,143	0.089212	5,182,856		462,373	
25.	Brace & Plaster Room	412,657	1,074,375	0.384090	1,176		452	
26.	Implants	50,914,270	212,215,039	0.239918	11,882,073		2,850,723	
27.	Cardiac Rehab	188,293	1,039,903	0.181068				
28.	Kidney Acquisition	6,358,076	5,901,534	1.077360	111,013		119,601	
29.	Heart Acquisition	2,540,980	3,624,758	0.701007	135,066		94,682	
30.	Liver Acquisition	2,865,857	2,707,403	1.058526	152,861		161,807	
31.	Lung Acquisition	2,794,426	2,339,984	1.194207	260,605		311,216	
32.	Pancreas Acquisition	546,944	18,146	30.141298				
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	158,377,304	388,292,852	0.407881	3,810,367		1,554,176	
44.	Emergency	33,041,490	238,321,949	0.138642				
45.	Observation	13,362,640	40,274,956	0.331785				
46.	Total				189,861,285		32,585,314	

* 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: 14-0088	Medicaid Provider Number: 3023
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)	170,071,527			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	122,529			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,388.01			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	14,458			
3.	Program general inpatient routine cost (Line 1c X Line 2)	20,067,849			
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)	20,067,849			

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	45,869,963	19,654	2,333.87	2,075	4,842,780
9.	Coronary Care Unit	8,055,482	2,564	3,141.76	510	1,602,298
10.	Burn ICU	3,411,669	1,542	2,212.50	277	612,863
11.	Nursery Special Care					
12.	Nursery ICU					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,336,781	2,800	834.56	515	429,798
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					32,585,314
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					60,140,902

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

Preliminary

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3023
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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
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 Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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:	14-0088	Medicaid Provider Number:	3023
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 Cath							
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
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:	14-0088	Medicaid Provider Number:	3023
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.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
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**

BHF Page 7

Preliminary

Medicare Provider Number: 14-0088		Medicaid Provider Number: 3023	
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)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	60,140,902	
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)	5,184,211	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	65,325,113	
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)	189,861,285	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	49,829,040	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	16,931,702	
	F. Coronary Care Unit	4,151,079	
	G. Burn ICU	2,350,874	
	H. Nursery Special Care		
	I. Nursery ICU		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,381,092	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	264,505,072	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		199,179,959
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: 14-0088	Medicaid Provider Number: 3023
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)	65,325,113	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	65,325,113	
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)	65,325,113	

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: 14-0088	Medicaid Provider Number: 3023
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)	199,179,959
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3023
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

	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:	14-0088	Medicaid Provider Number:	3023
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	9,134,608	520,010,789	0.017566	20,924,158		367,554	
2.	Recovery Room							
3.	Delivery and Labor Room	2,884,328	26,733,027	0.107894	4,988,991		538,282	
4.	Anesthesiology	6,104,169	184,078,756	0.033161	7,379,878		244,724	
5.	Radiology - Diagnostic	3,820,517	219,281,602	0.017423	9,592,395		167,128	
6.	Radiology - Therapeutic	903,720	132,905,744	0.006800	1,782,146		12,119	
7.	Nuclear Medicine							
8.	Laboratory	5,005,635	663,558,543	0.007544	33,550,999		253,109	
9.	Blood							
10.	Blood - Administration	32,469	122,278,030	0.000266	8,773,051		2,334	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	470,800	145,173,958	0.003243	9,672,058		31,366	
17.	EEG	671,026	35,623,953	0.018836	1,346,902		25,370	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	108,230	27,455,555	0.003942	3,113,310		12,273	
21.	Ambulance							
22.	CT Scan	541,150	281,738,350	0.001921	10,330,945		19,846	
23.	MRI	113,642	126,801,418	0.000896	3,699,498		3,315	
24.	Cardiac Cath	573,618	92,074,143	0.006230	5,182,856		32,289	
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	8,485,228	388,292,852	0.021853	3,810,367		83,268	
44.	Emergency	2,651,634	238,321,949	0.011126				
45.	Observation							
46.	Ancillary Total						1,792,977	

* 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:	14-0088	Medicaid Provider Number:	3023
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	22,931,986	122,529	187.16	14,458		2,705,959	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	4,075,619	19,654	207.37	2,075		430,293	
52.	Coronary Care Unit	1,062,052	2,564	414.22	510		211,252	
53.	Burn ICU	243,438	1,542	157.87	277		43,730	
54.	Nursery Special Care							
55.	Nursery ICU							
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)						3,391,234	
68.	Ancillary Total (from line 46)						1,792,977	
69.	Total (Lines 67-68)						5,184,211	

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3023
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	17,320		17,320
Newborn Days	515		515
Total Inpatient Revenue	264,505,072		264,505,072
Ancillary Revenue	189,861,285		189,861,285
Routine Revenue	74,643,787		74,643,787
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Room & Board costs split between Acute and Children's Hospital.

Observation Bed Days were adjusted by 1 to agree with the as filed W/S S-3 and split between Acute and Children's Hospital

BHF Page 3 - total costs agree with W/S C Part 1, column 1

GME costs were adjusted to as filed W/S B Part 1, column 25 and split between Acute and Children's Hospital.

Room & Board and GME costs were split for Adults & Peds, ICU, CCU, Burn ICU, and Nursery.