

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

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	☐ _____
☐ 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 Hospil 13031 for the cost report beginning 07/01/2017 and ending 06/30/2018 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

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

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	498	181,770		138,625	76.26%		31,130	5.36
2.	Psych	18	6,570		5,301	80.68%		1,205	4.40
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU	24	8,760		7,773	88.73%			
8.	Cardio Surgery ICU	7	2,555		2,083	81.53%			
9.	Cardiac ICU	7	2,555		2,010	78.67%			
10.	Pediatric ICU	21	7,655		4,541	59.32%			
11.	Neuro ICU	17	6,205		5,641	90.91%			
12.	Neonatal ICU	18	6,570		4,059	61.78%			
13.	Burn ICU	7	2,554		2,230	87.31%			
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	617	225,194		172,263	76.50%		32,335	5.33
23.	Observation Bed Days				7,186				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				595			117	6.81
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Trauma ICU				49				
8.	Cardio Surgery ICU				11				
9.	Cardiac ICU								
10.	Pediatric ICU				113				
11.	Neuro ICU				26				
12.	Neonatal ICU								
13.	Burn ICU				3				
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				797	0.46%		117	6.81

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	1,499	1,169,439

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

BHF Page 3

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
52-0098		13031	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2017	To: 06/30/2018

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (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	128,999,267	667,329,656	0.193307	1,460,772	594,433	282,377	114,908
2.	Recovery Room	23,979,775	72,735,146	0.329686	117,766	115,752	38,826	38,162
3.	Delivery and Labor Room							
4.	Anesthesiology	14,190,270	52,884,859	0.268324	108,121	58,215	29,011	15,620
5.	Radiology - Diagnostic	54,340,405	210,209,304	0.258506	238,916	238,835	61,761	61,740
6.	Radiology - Therapeutic	19,275,303	131,805,847	0.146240	12,845	190,348	1,878	27,836
7.	Nuclear Medicine	7,347,074	28,924,712	0.254007	10,347	15,700	2,628	3,988
8.	Laboratory	55,528,679	342,086,793	0.162323	650,586	327,144	105,605	53,103
9.	Blood							
10.	Blood - Administration	15,216,951	48,193,592	0.315746	97,021	79,348	30,634	25,054
11.	Intravenous Therapy							
12.	Respiratory Therapy	31,843,227	110,424,211	0.288372	717,297	14,077	206,848	4,059
13.	Physical Therapy	31,077,697	95,223,387	0.326366	184,106	28,877	60,086	9,424
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	37,738,310	197,510,827	0.191070	132,108	247,507	25,242	47,291
17.	EEG	5,467,152	23,765,465	0.230046	187,229	62,408	43,071	14,357
18.	Med. / Surg. Supplies	1,263,306	3,057,342	0.413204	278,366	138,650	115,022	57,291
19.	Drugs Charged to Patients	190,925,923	658,867,043	0.289779	1,258,570	763,938	364,707	221,373
20.	Renal Dialysis	4,757,986	12,459,639	0.381872	40,532		15,478	
21.	Ambulance	11,492,881	19,906,204	0.577352	232,470		134,217	
22.	CT Scan	11,196,232	211,264,329	0.052996	173,554	195,836	9,198	10,379
23.	MRI	15,044,133	158,952,051	0.094646	184,868	257,741	17,497	24,394
24.	Cardiac Rehab	1,569,616	3,722,602	0.421645				
25.	Neuropsych Testing	1,158,568	1,801,153	0.643237	1,533	109	986	70
26.	Clinic-CSC	90,027,909	129,137,356	0.697148	17,713	319,234	12,349	222,553
27.	Clinic-University Station	13,775,510	21,399,332	0.643736		23,921		15,399
28.	Clinic-Waisman	3,134,911	2,384,341	1.314791	261	15,373	343	20,212
29.	Clinic-West	21,807,236	39,728,865	0.548902	5,592	20,437	3,069	11,218
30.	Clinic-East	9,484,834	16,403,805	0.578209		9,098		5,261
31.	Clinic-Research Park	4,334,253	5,810,589	0.745923		8,246		6,151
32.	Pulmonary Function	1,363,947	5,446,892	0.250408	3,558	16,220	891	4,062
33.	Orthotics	3,535,010	7,005,775	0.504585		3,456		1,744
34.	Implantable Devices	62,856,453	76,498,910	0.821665	84,246	49,596	69,222	40,751
35.	Clinic-DHC	20,742,108	70,354,628	0.294822	164	11,271	48	3,323
36.	Clinic -The American Ctr	10,282,903	18,295,935	0.562032		7,197		4,045
37.	Clinic-Oakwood Village	42,607	43,524	0.978931				
38.	Clinic-Middleton Rehab	642,607	1,844,309	0.348427		1,723		600
39.	Clinic-Aoda	188,339	201,178	0.936181				
40.	Clinic-Kidney	829,603	877,395	0.945530				
41.	Clinic-Pain Management	3,395,480	4,485,990	0.756908		2,066		1,564
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	39,128,078	172,241,580	0.227170	159,580	112,663	36,252	25,594
45.	Observation	9,739,689	46,401,132	0.209902		267,497		56,148
46.	Total				6,358,121	4,196,916	1,667,246	1,147,674

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

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	197,627,833	5,824,632		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	145,811	5,301		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,355.37	1,098.78		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	595			
3.	Program general inpatient routine cost (Line 1c X Line 2)	806,445			
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)	806,445			

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	20,907,480	7,773	2,689.76	49	131,798
11.	Cardio Surgery ICU	6,965,474	2,083	3,343.96	11	36,784
12.	Cardiac ICU	5,018,750	2,010	2,496.89		
13.	Pediatric ICU	12,731,308	4,541	2,803.64	113	316,811
14.	Neuro ICU	14,449,606	5,641	2,561.53	26	66,600
15.	Neonatal ICU	10,466,216	4,059	2,578.52		
16.	Burn ICU	6,305,243	2,230	2,827.46	3	8,482
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)					1,667,246
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,034,166

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

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.	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) (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:		Medicaid Provider Number:	
52-0098		13031	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2017	To: 06/30/2018

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	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.	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: 07/01/2017 To: 06/30/2018

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	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: 07/01/2017 To: 06/30/2018	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		1,147,674
2.	Inpatient Operating Services (BHF Page 4, Line 25)	3,034,166	
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)	265,507	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,299,673	1,147,674
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	74.00%	26.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	6,358,121	4,196,916
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,068,607	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Trauma ICU	409,107	
	H. Cardio Surgery ICU	34,497	
	I. Cardiac ICU		
	J. Pediatric ICU	988,584	
	K. Neuro ICU	210,714	
	L. Neonatal ICU		
	M. Burn ICU	12,996	
	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)	10,082,626	4,196,916
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		9,832,195
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: 07/01/2017 To: 06/30/2018

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)	3,299,673	1,147,674
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,299,673	1,147,674
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)	3,299,673	1,147,674

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:	Medicaid Provider Number:
52-0098	13031
Program:	Period Covered by Statement:
Medicaid Hospital	From: 07/01/2017 To: 06/30/2018

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	9,832,195
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: 07/01/2017 To: 06/30/2018

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
52-0098		13031	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2017	To: 06/30/2018

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
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.	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:		Medicaid Provider Number:	
52-0098		13031	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2017	To: 06/30/2018

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	65,065,404	145,811	446.23	595		265,507	
48.	Psych	480,207	5,301	90.59				
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)						265,507	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						265,507	

Preliminary

Medicare Provider Number: 52-0098	Medicaid Provider Number: 13031
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2017 To: 06/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	797		797
Newborn Days			
Total Inpatient Revenue	10,082,757	(131)	10,082,626
Ancillary Revenue	6,358,252	(131)	6,358,121
Routine Revenue	3,724,505		3,724,505
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	1,499		1,499
Total Outpatient Revenue	4,197,105	(189)	4,196,916
Outpatient Received and Receivable			

Notes:

[illegible]