

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 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: 07/01/2017	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 Illinois Hospital & 3098 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:	14-0150	Medicaid Provider Number:	3098
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	303	110,595		67,977	61.46%		19,291	5.08
2.	Psych	53	19,345		12,525	64.75%		974	12.86
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,330		13,342	87.03%			
6.	Coronary Care Unit	19	6,935		5,859	84.48%			
7.	Pediatric ICU	18	6,570		1,779	27.08%			
8.	Neonatal ICU	52	18,980		9,121	48.06%			
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				3,490				
22.	Total	487	177,755		114,093	64.19%		20,265	5.46
23.	Observation Bed Days				6,721				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				3,883			157	24.73
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				3,883	3.40%		157	24.73

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		556,678

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

BHF Page 3

PRELIMINARY

Medicare Provider Number:			Medicaid Provider Number:		
14-0150			3098		
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)	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)		(4)	(5)	(6)	(7)
1.	Operating Room	48,944,020	167,401,310	0.292375	8,078		2,362	
2.	Recovery Room	10,307,711	13,762,347	0.748979	37,630		28,184	
3.	Delivery and Labor Room	22,200,575	41,877,848	0.530127	6,495		3,443	
4.	Anesthesiology	4,426,931	77,540,601	0.057092	6,087		348	
5.	Radiology - Diagnostic	8,971,298	36,534,192	0.245559	16,966		4,166	
6.	Radiology - Therapeutic	9,216,082	23,408,560	0.393706				
7.	Nuclear Medicine	1,939,631	6,807,337	0.284932				
8.	Laboratory	47,771,456	371,188,597	0.128699	581,024		74,777	
9.	Blood							
10.	Blood - Administration	8,650,219	38,931,188	0.222193	2,436		541	
11.	Intravenous Therapy	687,682	4,105,752	0.167492				
12.	Respiratory Therapy	8,324,878	43,653,468	0.190704	13,840		2,639	
13.	Physical Therapy	15,160,241	24,027,178	0.630962	14,446		9,115	
14.	Occupational Therapy	5,074,098	8,211,007	0.617963	459,262		283,807	
15.	Speech Pathology	1,158,594	1,959,417	0.591295	2,922		1,728	
16.	EKG	569,873	5,109,320	0.111536	25,657		2,862	
17.	EEG	1,068,669	9,397,506	0.113718	23,717		2,697	
18.	Med. / Surg. Supplies	82,565,624	215,009,982	0.384008	194,505		74,691	
19.	Drugs Charged to Patients	93,111,731	334,235,830	0.278581	1,167,482		325,238	
20.	Renal Dialysis	11,694,349	35,747,822	0.327135				
21.	Ambulance							
22.	Ultrasound	2,872,057	16,669,035	0.172299	13,128		2,262	
23.	Radiology Angiography	7,030,611	62,086,036	0.113240				
24.	Radiology W. Harrison	2,836,465	15,771,746	0.179845				
25.	CT Scan	7,049,652	101,315,340	0.069581	13,890		966	
26.	MRI	7,455,913	67,563,999	0.110353	48,062		5,304	
27.	Cardiac Catheterization	2,991,310	22,146,595	0.135069				
28.	Lab Tissue Typing	1,990,069	5,951,492	0.334382				
29.	Lab Outreach	13,543,789	163,367,912	0.082904				
30.	Gastroenterology	7,364,086	34,240,612	0.215069	2,221		478	
31.	Bone Marrow Transplant	3,176,441	4,799,763	0.661791				
32.	Cardiac Services	6,226,061	32,969,661	0.188842	5,584		1,054	
33.	Kidney Acquisition	11,109,357	12,845,250	0.864861				
34.	Liver Acquisition	2,813,042	5,189,452	0.542069				
35.	Pancreas Acquisition	1,080,980	1,898,580	0.569362				
36.	Other Organ Acquisition	246,768	184,160	1.339965				
37.	Radio Mile Square	729,821	2,221,301	0.328556	264		87	
38.	Telemedicine Prgm	3,019,063	1,472,795	2.049887				
39.	Sleep Lab West Harr	2,099,575	5,777,751	0.363390				
40.	Sickle Cell Clinic	2,465,060	4,955,416	0.497448				
41.	Heart Ctr	188,705	556,729	0.338953				
42.	Hyperbaric Oxygen Ther.	291,469	240,867	1.210083				
Outpatient Service Cost Centers								
43.	Clinic	114,220,820	170,959,127	0.668118	83		55	
44.	Emergency	25,257,600	93,524,980	0.270063	210,392		56,819	
45.	Observation	13,984,116	18,984,643	0.736601				
46.	Total				2,854,171		883,623	

* 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: 14-0150	Medicaid Provider Number: 3098
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)	155,420,815	22,911,201		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,698	12,525		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,080.66	1,829.24		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		3,883		
3.	Program general inpatient routine cost (Line 1c X Line 2)		7,102,939		
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)		7,102,939		

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	41,951,326	13,342	3,144.31		
9.	Coronary Care Unit	21,663,054	5,859	3,697.40		
10.	Pediatric ICU	9,225,851	1,779	5,185.98		
11.	Neonatal ICU	23,991,709	9,121	2,630.38		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,958,549	3,490	847.72		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					883,623
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					7,986,562

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

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
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.	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 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:	14-0150	Medicaid Provider Number:	3098
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 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.	Hyperbaric 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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
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.	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**

BHF Page 7

PRELIMINARY

Medicare Provider Number: 14-0150		Medicaid Provider Number: 3098	
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)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	7,986,562	
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)	458,281	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	8,444,843	
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)	2,854,171	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	8,819,608	
	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)	11,673,779	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,228,936
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: 14-0150	Medicaid Provider Number: 3098
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)	8,444,843	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	8,444,843	
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)	8,444,843	

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:
14-0150	3098
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)	3,228,936
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: 14-0150	Medicaid Provider Number: 3098
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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	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	10,511,133	167,401,310	0.062790	8,078		507	
2.	Recovery Room	111,489	13,762,347	0.008101	37,630		305	
3.	Delivery and Labor Room	1,597,625	41,877,848	0.038150	6,495		248	
4.	Anesthesiology	2,650,036	77,540,601	0.034176	6,087		208	
5.	Radiology - Diagnostic	295,963	36,534,192	0.008101	16,966		137	
6.	Radiology - Therapeutic	2,777,073	23,408,560	0.118635				
7.	Nuclear Medicine	337,926	6,807,337	0.049641				
8.	Laboratory	11,483,315	371,188,597	0.030937	581,024		17,975	
9.	Blood							
10.	Blood - Administration	2,026,203	38,931,188	0.052046	2,436		127	
11.	Intravenous Therapy	33,261	4,105,752	0.008101				
12.	Respiratory Therapy	2,205,848	43,653,468	0.050531	13,840		699	
13.	Physical Therapy	583,467	24,027,178	0.024284	14,446		351	
14.	Occupational Therapy	271,533	8,211,007	0.033069	459,262		15,187	
15.	Speech Pathology	213,819	1,959,417	0.109124	2,922		319	
16.	EKG	621,091	5,109,320	0.121560	25,657		3,119	
17.	EEG	76,129	9,397,506	0.008101	23,717		192	
18.	Med. / Surg. Supplies	4,194,916	215,009,982	0.019510	194,505		3,795	
19.	Drugs Charged to Patients	13,912,819	334,235,830	0.041626	1,167,482		48,598	
20.	Renal Dialysis	1,773,506	35,747,822	0.049612				
21.	Ambulance							
22.	Ultrasound	396,608	16,669,035	0.023793	13,128		312	
23.	Radiology Angiography	2,602,603	62,086,036	0.041919				
24.	Radiology W. Harrison	127,767	15,771,746	0.008101				
25.	CT Scan	2,043,781	101,315,340	0.020172	13,890		280	
26.	MRI	1,742,083	67,563,999	0.025784	48,062		1,239	
27.	Cardiac Catheterization	2,752,711	22,146,595	0.124295				
28.	Lab Tissue Typing	48,213	5,951,492	0.008101				
29.	Lab Outreach	1,323,443	163,367,912	0.008101				
30.	Gastroenterology	277,383	34,240,612	0.008101	2,221		18	
31.	Bone Marrow Transplant	38,883	4,799,763	0.008101				
32.	Cardiac Services	267,087	32,969,661	0.008101	5,584		45	
33.	Kidney Acquisition	443,395	12,845,250	0.034518				
34.	Liver Acquisition	353,098	5,189,452	0.068041				
35.	Pancreas Acquisition	15,380	1,898,580	0.008101				
36.	Other Organ Acquisition	72,187	184,160	0.391980				
37.	Radio Mile Square	17,995	2,221,301	0.008101	264		2	
38.	Telemedicine Prgm	11,931	1,472,795	0.008101				
39.	Sleep Lab West Harr	46,806	5,777,751	0.008101				
40.	Sickle Cell Clinic	40,144	4,955,416	0.008101				
41.	Heart Ctr	4,510	556,729	0.008101				
42.	Hyperbaric Oxygen Ther.	1,951	240,867	0.008100				
	Outpatient Ancillary Centers							
43.	Clinic	5,025,737	170,959,127	0.029397	83		2	
44.	Emergency	2,814,873	93,524,980	0.030098	210,392		6,332	
45.	Observation							
46.	Ancillary Total						99,997	

* 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:	14-0150	Medicaid Provider Number:	3098
Program:	Medicaid-Hospital	Period Covered by Statement:	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	8,332,174	74,698	111.54				
48.	Psych	1,155,621	12,525	92.27	3,883		358,284	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,556,659	13,342	116.67				
52.	Coronary Care Unit	1,188,796	5,859	202.90				
53.	Pediatric ICU	666,073	1,779	374.41				
54.	Neonatal ICU	2,345,206	9,121	257.12				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	192,177	3,490	55.07				
67.	Routine Total (lines 47-66)						358,284	
68.	Ancillary Total (from line 46)						99,997	
69.	Total (Lines 67-68)						458,281	

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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	3,883		3,883
Newborn Days			
Total Inpatient Revenue	11,673,779		11,673,779
Ancillary Revenue	2,854,171		2,854,171
Routine Revenue	8,819,608		8,819,608
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Reclassified Blood charges as Blood Admin.

BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1, as directed in the instructions. Not sure where filed numbers came from.

Clinic costs and charges include Medicare lines 93.01, 93.02, and 93.03.

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

BHF Page 3-Filed report did not list all ancillary cost centers but BHF could trace to Medicare report.