

Hospital Statement of Cost

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

General Information **PRELIMINARY**

Name of Hospital: University of Illinois Hospital & Health Sciences		Medicare Provider Number: 14-0150
Street: 1740 W. Taylor Street		Medicaid Provider Number: 3098
City: Chicago	State: Illinois	Zip: 60612
Period Covered by Statement:	From: 07/01/2015	To: 06/30/2016

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input checked="" type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> 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 Illinois Hospital . 3098 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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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	312	114,192		66,720	58.43%		19,613	5.06
2.	Psych	53	19,398		12,001	61.87%		935	12.84
3.	Rehab	18	6,588		3,823	58.03%		318	12.02
4.	Other (Sub)								
5.	Intensive Care Unit	45	16,470		13,018	79.04%			
6.	Coronary Care Unit	19	6,954		5,620	80.82%			
7.	Pediatric ICU	18	6,588		2,675	40.60%			
8.	Neonatal ICU	52	19,032		11,215	58.93%			
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	25	9,150		3,874	42.34%			
22.	Total	542	198,372		118,946	59.96%		20,866	5.51
23.	Observation Bed Days				7,313				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,189			1,814	6.95
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,062				
6.	Coronary Care Unit				384				
7.	Pediatric ICU				1,553				
8.	Neonatal ICU				2,417				
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				467				
22.	Total				13,072	10.99%		1,814	6.95

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	129,714	485,192

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

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	43,929,977	154,752,077	0.283873	5,020,399	5,334,977	1,425,156	1,514,456
2.	Recovery Room	9,070,462	14,041,933	0.645955	251,160	575,530	162,238	371,766
3.	Delivery and Labor Room	14,379,239	31,336,107	0.458871	1,935,969	526,241	888,360	241,477
4.	Anesthesiology	3,937,723	68,084,950	0.057835	2,831,538	2,135,465	163,762	123,505
5.	Radiology - Diagnostic	7,228,057	31,886,655	0.226680	700,494	904,103	158,788	204,942
6.	Radiology - Therapeutic	8,531,019	20,052,000	0.425445	169,439	1,087,092	72,087	462,498
7.	Nuclear Medicine	2,098,409	6,882,415	0.304894	112,523	185,896	34,308	56,679
8.	Laboratory	42,353,842	315,116,348	0.134407	10,537,113	11,095,616	1,416,262	1,491,328
9.	Blood							
10.	Blood - Administration	7,770,825	36,673,802	0.211890	2,645,514	610,733	560,558	129,408
11.	Intravenous Therapy	834,949	2,397,452	0.348265	161,583	3,783	56,274	1,317
12.	Respiratory Therapy	6,938,045	42,265,297	0.164155	4,561,924	205,152	748,863	33,677
13.	Physical Therapy	11,612,333	24,074,034	0.482359	346,655	644,299	167,212	310,783
14.	Occupational Therapy	3,691,364	7,423,747	0.497237	200,857	206,970	99,874	102,913
15.	Speech Pathology	960,384	1,958,053	0.490479	151,069	160,951	74,096	78,943
16.	EKG	459,447	4,762,965	0.096462	193,804	100,503	18,695	9,695
17.	EEG	794,901	7,942,057	0.100088	872,900	95,469	87,367	9,555
18.	Med. / Surg. Supplies	65,940,167	199,887,479	0.329886	8,175,732	3,688,737	2,697,060	1,216,863
19.	Drugs Charged to Patients	86,897,537	298,943,553	0.290682	20,606,872	2,795,601	5,990,047	812,631
20.	Renal Dialysis	9,830,676	35,967,429	0.273322	509,405	974,113	139,232	266,247
21.	Ambulance							
22.	Ultrasound	2,417,889	13,962,438	0.173171	464,316	414,729	80,406	71,819
23.	Radiology Angiography	6,539,898	58,794,791	0.111233	2,847,896	668,051	316,780	74,309
24.	Radiology W. Harrison	2,954,494	15,870,769	0.186159	3,405	599,968	634	111,689
25.	CT Scan	5,259,011	79,361,929	0.066266	2,471,258	1,984,275	163,760	131,490
26.	MRI	5,480,065	53,217,473	0.102975	1,771,981	1,689,929	182,470	174,020
27.	Cardiac Catheterization	2,391,478	15,696,657	0.152356	497,632	121,139	75,817	18,456
28.	Lab Tissue Typing	1,423,730	4,226,856	0.336830	28,730	91,144	9,677	30,700
29.	Lab Outreach	11,674,605	140,777,025	0.082930				
30.	Gastroenterology	5,649,149	26,237,471	0.215308	439,599	423,585	94,649	91,201
31.	Bone Marrow Transplant	2,472,458	3,675,108	0.672758	397,510	36,561	267,428	24,597
32.	Cardiac Services	4,666,396	26,620,817	0.175291	1,135,365	386,359	199,019	67,725
33.	Kidney Acquisition	7,925,883	7,767,314	1.020415	165,262		168,636	
34.	Liver Acquisition	1,827,206	2,876,575	0.635202	229,610		145,849	
35.	Pancreas Acquisition	750,744	1,722,075	0.435953	114,805		50,050	
36.	Other Organ Acquisition	435,379	417,595	1.042587				
37.	Radio Mile Square	576,929	1,741,655	0.331253		83,829		27,769
38.	Telemedicine Prgm	2,799,154	1,468,789	1.905756				
39.	Sleep Lab West Harr	1,559,622	4,357,749	0.357896		203,584		72,862
40.	Sickle Cell Clinic	1,711,625	2,905,024	0.589195	8,865	117,064	5,223	68,974
41.	Heart Ctr	94,665	311,064	0.304326		9,170		2,791
42.	Hyperbarid Oxygen Ther.	150,454	36,208	4.155270				
Outpatient Service Cost Centers								
43.	Clinic	96,742,997	149,831,732	0.645678	8,605	8,931,545	5,556	5,766,902
44.	Emergency	17,629,249	93,512,404	0.188523	2,262,748	4,070,429	426,580	767,369
45.	Observation	11,600,173	17,873,967	0.648998	57,180	1,210,395	37,110	785,544
46.	Total				72,889,717	52,372,987	17,189,883	15,726,900

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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)	117,433,903	17,595,262	5,643,510	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,033	12,001	3,823	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,586.24	1,466.15	1,476.20	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,189			
3.	Program general inpatient routine cost (Line 1c X Line 2)	11,403,479			
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)	11,403,479			

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	32,519,128	13,018	2,498.01	1,062	2,652,887
9.	Coronary Care Unit	15,955,213	5,620	2,839.01	384	1,090,180
10.	Pediatric ICU	9,246,673	2,675	3,456.70	1,553	5,368,255
11.	Neonatal ICU	24,205,034	11,215	2,158.27	2,417	5,216,539
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,979,178	3,874	769.02	467	359,132
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					17,189,883
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					43,280,355

**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: 07/01/2015 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.	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)	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)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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.	Ultrasound							
23.	Radiology Angiography							
24.	Radiology W. Harrison							
25.	CT Scan							
26.	MRI							
27.	Cardiac Catheterization							
28.	Lab Tissue Typing							
29.	Lab Outreach							
30.	Gastroenterology							
31.	Bone Marrow Transplant							
32.	Cardiac Services							
33.	Kidney Acquisition							
34.	Liver Acquisition							
35.	Pancreas Acquisition							
36.	Other Organ Acquisition							
37.	Radio Mile Square							
38.	Telemedicine Prgm							
39.	Sleep Lab West Harr							
40.	Sickle Cell Clinic							
41.	Heart Ctr							
42.	Hyperbarid Oxygen Ther.							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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.	Pediatric ICU							
54.	Neonatal ICU							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

PRELIMINARY

Medicare Provider Number: 14-0150		Medicaid Provider Number: 3098	
Program: Medicaid-Hospital		Period Covered by Statement: From: 07/01/2015 To: 06/30/2016	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		15,726,900
2.	Inpatient Operating Services (BHF Page 4, Line 25)	43,280,355	
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)	4,396,260	1,769,174
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	47,676,615	17,496,074
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	73.00%	27.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	72,889,717	52,372,987
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	12,594,815	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,892,234	
	F. Coronary Care Unit	1,494,548	
	G. Pediatric ICU	3,769,225	
	H. Neonatal ICU	7,580,220	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	520,036	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	102,740,795	52,372,987
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		89,941,093
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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)	47,676,615	17,496,074
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	47,676,615	17,496,074
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)	47,676,615	17,496,074

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.

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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)	89,941,093
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
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 (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 07/01/2015 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: 14-0150	Medicaid Provider Number: 3098
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	9,167,299	154,752,077	0.059239	5,020,399	5,334,977	297,403	316,039
2.	Recovery Room	122,923	14,041,933	0.008754	251,160	575,530	2,199	5,038
3.	Delivery and Labor Room	1,342,338	31,336,107	0.042837	1,935,969	526,241	82,931	22,543
4.	Anesthesiology	2,321,424	68,084,950	0.034096	2,831,538	2,135,465	96,544	72,811
5.	Radiology - Diagnostic	279,136	31,886,655	0.008754	700,494	904,103	6,132	7,915
6.	Radiology - Therapeutic	2,383,574	20,052,000	0.118870	169,439	1,087,092	20,141	129,223
7.	Nuclear Medicine	301,565	6,882,415	0.043817	112,523	185,896	4,930	8,145
8.	Laboratory	9,991,014	315,116,348	0.031706	10,537,113	11,095,616	334,090	351,798
9.	Blood							
10.	Blood - Administration	1,781,003	36,673,802	0.048563	2,645,514	610,733	128,474	29,659
11.	Intravenous Therapy	20,987	2,397,452	0.008754	161,583	3,783	1,414	33
12.	Respiratory Therapy	1,950,608	42,265,297	0.046152	4,561,924	205,152	210,542	9,468
13.	Physical Therapy	542,553	24,074,034	0.022537	346,655	644,299	7,813	14,521
14.	Occupational Therapy	239,941	7,423,747	0.032321	200,857	206,970	6,492	6,689
15.	Speech Pathology	186,062	1,958,053	0.095024	151,069	160,951	14,355	15,294
16.	EKG	536,392	4,762,965	0.112617	193,804	100,503	21,826	11,318
17.	EEG	69,525	7,942,057	0.008754	872,900	95,469	7,641	836
18.	Med. / Surg. Supplies	3,843,229	199,887,479	0.019227	8,175,732	3,688,737	157,195	70,923
19.	Drugs Charged to Patients	12,179,091	298,943,553	0.040740	20,606,872	2,795,601	839,524	113,893
20.	Renal Dialysis	1,676,100	35,967,429	0.046600	509,405	974,113	23,738	45,394
21.	Ambulance							
22.	Ultrasound	345,444	13,962,438	0.024741	464,316	414,729	11,488	10,261
23.	Radiology Angiography	2,306,460	58,794,791	0.039229	2,847,896	668,051	111,720	26,207
24.	Radiology W. Harrison	138,933	15,870,769	0.008754	3,405	599,968	30	5,252
25.	CT Scan	1,738,425	79,361,929	0.021905	2,471,258	1,984,275	54,133	43,466
26.	MRI	1,485,425	53,217,473	0.027912	1,771,981	1,689,929	49,460	47,169
27.	Cardiac Catheterization	2,333,383	15,696,657	0.148655	497,632	121,139	73,975	18,008
28.	Lab Tissue Typing	37,002	4,226,856	0.008754	28,730	91,144	252	798
29.	Lab Outreach	1,232,362	140,777,025	0.008754				
30.	Gastroenterology	229,683	26,237,471	0.008754	439,599	423,585	3,848	3,708
31.	Bone Marrow Transplant	32,172	3,675,108	0.008754	397,510	36,561	3,480	320
32.	Cardiac Services	233,039	26,620,817	0.008754	1,135,365	386,359	9,939	3,382
33.	Kidney Acquisition	357,574	7,767,314	0.046036	165,262		7,608	
34.	Liver Acquisition	290,629	2,876,575	0.101033	229,610		23,198	
35.	Pancreas Acquisition	15,075	1,722,075	0.008754	114,805		1,005	
36.	Other Organ Acquisition	63,985	417,595	0.153223				
37.	Radio Mile Square	15,246	1,741,655	0.008754		83,829		734
38.	Telemedicine Prgm	12,858	1,468,789	0.008754				
39.	Sleep Lab West Harr	38,148	4,357,749	0.008754		203,584		1,782
40.	Sickle Cell Clinic	25,431	2,905,024	0.008754	8,865	117,064	78	1,025
41.	Heart Ctr	2,723	311,064	0.008754		9,170		80
42.	Hyperbarid Oxygen Ther.	317	36,208	0.008755				
	Outpatient Ancillary Centers							
43.	Clinic	4,418,568	149,831,732	0.029490	8,605	8,931,545	254	263,391
44.	Emergency	2,574,180	93,512,404	0.027528	2,262,748	4,070,429	62,289	112,051
45.	Observation							
46.	Ancillary Total						2,676,141	1,769,174

* 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: 07/01/2015 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	7,269,617	74,033	98.19	7,189		705,888	
48.	Psych	1,003,440	12,001	83.61				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,379,832	13,018	105.99	1,062		112,561	
52.	Coronary Care Unit	1,035,454	5,620	184.24	384		70,748	
53.	Pediatric ICU	612,156	2,675	228.84	1,553		355,389	
54.	Neonatal ICU	2,110,470	11,215	188.18	2,417		454,831	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	171,737	3,874	44.33	467		20,702	
67.	Routine Total (lines 47-66)						1,720,119	
68.	Ancillary Total (from line 46)						2,676,141	1,769,174
69.	Total (Lines 67-68)						4,396,260	1,769,174

