

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: 07/01/2019	To: 06/30/2020

Type of Control

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

Type of Hospital

☐ XXXX General Short-Term XXXX	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify)

Health Care Program

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

☐ XXXX Medicaid Hospital XXXX	☐ 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 Chicago Medical 3023 for the cost report beginning 07/01/2019 and ending 06/30/2020 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
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: 07/01/2019 To: 06/30/2020

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	445	162,870		131,011	80.44%		23,853	6.70
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	56	20,496		17,042	83.15%			
6.	Coronary Care Unit	28	10,248		9,353	91.27%			
7.	Burn ICU	8	2,928		2,441	83.37%			
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				8,138				
22.	Total	537	196,542		167,985	85.47%		23,853	6.70
23.	Observation Bed Days				10,328				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				9,166			1,802	6.36
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,728				
6.	Coronary Care Unit				422				
7.	Burn ICU				145				
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				2,443				
22.	Total				13,904	8.28%		1,802	6.36

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: 07/01/2019	To: 06/30/2020

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	95,131,876	575,657,548	0.165258	18,147,085		2,998,951	
2.	Recovery Room	28,738,661	88,497,307	0.324741	4,299		1,396	
3.	Delivery and Labor Room	17,022,569	37,401,362	0.455132	3,770,122		1,715,903	
4.	Anesthesiology	15,236,965	253,656,303	0.060069	6,847,575		411,327	
5.	Radiology - Diagnostic	42,380,741	254,550,695	0.166492	6,821,956		1,135,801	
6.	Radiology - Therapeutic	21,403,039	172,766,733	0.123884	264,269		32,739	
7.	Nuclear Medicine	12,727,254	53,739,626	0.236832				
8.	Laboratory	76,161,789	#####	0.071360	29,963,825		2,138,219	
9.	Blood							
10.	Blood - Administration	24,111,940	145,648,880	0.165548	7,164,094		1,186,001	
11.	Intravenous Therapy							
12.	Respiratory Therapy	26,844,757	147,857,307	0.181559	5,539,828		1,005,806	
13.	Physical Therapy	14,016,717	50,517,911	0.277460	1,198,417		332,513	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	21,838,712	231,013,309	0.094534	4,821,105		455,758	
17.	EEG	7,576,592	37,517,632	0.201948	1,055,777		213,212	
18.	Med. / Surg. Supplies	50,208,058	182,822,049	0.274628	4,422,729		1,214,605	
19.	Drugs Charged to Patients	227,071,585	#####	0.130990	26,043,230		3,411,403	
20.	Renal Dialysis	7,780,599	41,857,297	0.185884	2,916,535		542,137	
21.	Ambulance	1,733,500	11,998	144.482414				
22.	CT Scan	12,469,300	450,739,966	0.027664	13,070,517		361,583	
23.	MRI	11,114,863	165,771,457	0.067049	2,653,220		177,896	
24.	Cardiac Cath	9,090,050	97,312,681	0.093411	2,208,418		206,291	
25.	Brace & Plaster Room	308,704	671,197	0.459931				
26.	Implants	55,317,071	275,749,628	0.200606	6,495,396		1,303,015	
27.	Cardiac Rehab	264,151	1,924,929	0.137226				
28.	Kidney Acquisition	7,815,920	12,764,335	0.612325	141,212		86,468	
29.	Heart Acquisition	3,658,418	6,894,006	0.530666	164,143		87,105	
30.	Liver Acquisition	5,353,292	11,705,927	0.457315	185,770		84,955	
31.	Lung Acquisition	2,310,940	4,791,209	0.482329				
32.	Pancreas Acquisition	799,835	861,597	0.928317				
33.	Islet Acquisition							
34.	Ultra Sound	2,394,048	29,831,615	0.080252				
35.	Allogeneic	2,711,941	6,696,682	0.404968				
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics	19,058,037	133,267,391	0.143006				
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	186,903,521	551,239,948	0.339060	3,433,302		1,164,095	
44.	Emergency	72,913,813	383,050,698	0.190350	9,954,468		1,894,833	
45.	Observation	20,032,234	72,441,152	0.276531	579,044		160,124	
46.	Total				157,866,336		22,322,136	

* 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: 07/01/2019 To: 06/30/2020

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)	222,549,541			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	141,339			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,574.58			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	9,166			
3.	Program general inpatient routine cost (Line 1c X Line 2)	14,432,600			
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)	14,432,600			

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	54,187,437	17,042	3,179.64	1,728	5,494,418
9.	Coronary Care Unit	22,073,892	9,353	2,360.09	422	995,958
10.	Burn ICU	6,458,030	2,441	2,645.65	145	383,619
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	11,460,731	8,138	1,408.30	2,443	3,440,477
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					22,322,136
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					47,069,208

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: 07/01/2019 To: 06/30/2020

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.	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)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient (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: 07/01/2019 To: 06/30/2020

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.	Islet Acquisition							
34.	Ultra Sound							
35.	Allogeneic							
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics							
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: 07/01/2019 To: 06/30/2020

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: 07/01/2019 To: 06/30/2020

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)	47,069,208	
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)	3,447,320	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	50,516,528	
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)	157,866,336	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	31,591,142	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	18,819,765	
	F. Coronary Care Unit	4,284,220	
	G. Burn ICU	1,362,222	
	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	11,635,035	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	225,558,720	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		175,042,192
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: 07/01/2019 To: 06/30/2020

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)	50,516,528	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	50,516,528	
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)	50,516,528	

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: 07/01/2019 To: 06/30/2020

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)	175,042,192
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)	(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: 07/01/2019 To: 06/30/2020

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:	
14-0088		3023	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 07/01/2019	To: 06/30/2020

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	16,567,547	575,657,548	0.028780	18,147,085		522,273	
2.	Recovery Room							
3.	Delivery and Labor Room	2,223,601	37,401,362	0.059452	3,770,122		224,141	
4.	Anesthesiology	8,275,860	253,656,303	0.032626	6,847,575		223,409	
5.	Radiology - Diagnostic	4,186,068	254,550,695	0.016445	6,821,956		112,187	
6.	Radiology - Therapeutic	4,730,759	172,766,733	0.027382	264,269		7,236	
7.	Nuclear Medicine							
8.	Laboratory	2,958,208	#####	0.002772	29,963,825		83,060	
9.	Blood							
10.	Blood - Administration	1,060,365	145,648,880	0.007280	7,164,094		52,155	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,024,151	231,013,309	0.013091	4,821,105		63,113	
17.	EEG	3,661,161	37,517,632	0.097585	1,055,777		103,028	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	948,262	41,857,297	0.022655	2,916,535		66,074	
21.	Ambulance							
22.	CT Scan	374,557	450,739,966	0.000831	13,070,517		10,862	
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.	Islet Acquisition							
34.	Ultra Sound							
35.	Allogeneic							
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	9,722,653	551,239,948	0.017638	3,433,302		60,557	
44.	Emergency	5,874,213	383,050,698	0.015335	9,954,468		152,652	
45.	Observation							
46.	Ancillary Total						1,680,747	

* 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: 07/01/2019 To: 06/30/2020

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	16,197,151	141,339	114.60	9,166		1,050,424	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,911,036	17,042	170.82	1,728		295,177	
52.	Coronary Care Unit	2,349,476	9,353	251.20	422		106,006	
53.	Burn ICU	296,744	2,441	121.57	145		17,628	
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	990,465	8,138	121.71	2,443		297,338	
67.	Routine Total (lines 47-66)						1,766,573	
68.	Ancillary Total (from line 46)						1,680,747	
69.	Total (Lines 67-68)						3,447,320	

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3023
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,461		11,461
Newborn Days	2,443		2,443
Total Inpatient Revenue	225,558,720		225,558,720
Ancillary Revenue	157,866,336		157,866,336
Routine Revenue	67,692,384		67,692,384
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]