

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

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 07/01/2019 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

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: 07/01/2019 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	303	103,149		68,805	66.70%		18,033	5.53
2.	Psych	50	18,300		12,415	67.84%		863	14.39
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,372		13,571	88.28%			
6.	Coronary Care Unit	19	6,954		6,384	91.80%			
7.	Pediatric ICU	18	6,588		1,315	19.96%			
8.	Neonatal ICU	52	19,032		9,721	51.08%			
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				2,890				
22.	Total	484	169,395		115,101	67.95%		18,896	5.94
23.	Observation Bed Days				5,534				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,003			1,396	6.30
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				820				
6.	Coronary Care Unit				390				
7.	Pediatric ICU				231				
8.	Neonatal ICU				3,357				
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				1,398				
22.	Total				10,199	8.86%		1,396	6.30

Line No.	Program	Total Hospital
1.	Part III - Outpatient Statistics - Occasions of Service	
1.	Total Outpatient Occasions of Service	135,987
		508,656

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: 07/01/2019	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)		(4)	(5)	(6)	(7)
1.	Operating Room	55,066,878	172,890,310	0.318508	4,385,181	3,204,428	1,396,715	1,020,636
2.	Recovery Room	10,884,408	13,394,859	0.812581	231,113	300,245	187,798	243,973
3.	Delivery and Labor Room	27,566,614	44,843,677	0.614727	4,758,566	693,228	2,925,219	426,146
4.	Anesthesiology	4,881,401	78,477,975	0.062201	3,577,358	1,229,459	222,515	76,474
5.	Radiology - Diagnostic	17,389,854	37,956,422	0.458153	991,925	758,009	454,453	347,284
6.	Radiology - Therapeutic	8,640,659	22,254,667	0.388263	167,044	715,613	64,857	277,846
7.	Nuclear Medicine	1,724,055	5,501,120	0.313401	167,211	128,674	52,404	40,327
8.	Laboratory	52,954,850	408,297,122	0.129697	14,585,739	9,585,456	1,891,727	1,243,205
9.	Blood							
10.	Blood - Administration	9,528,121	45,003,045	0.211722	3,131,653	419,277	663,040	88,770
11.	Intravenous Therapy	1,146,801	4,611,864	0.248663	307,489	11,952	76,461	2,972
12.	Respiratory Therapy	10,353,687	53,358,624	0.194040	6,504,746	122,458	1,262,181	23,762
13.	Physical Therapy	18,155,657	24,484,769	0.741508	603,531	266,271	447,523	197,442
14.	Occupational Therapy	6,745,283	9,433,080	0.715067	543,945	96,815	388,957	69,229
15.	Speech Pathology	2,069,275	4,229,962	0.489195	124,597	98,530	60,952	48,200
16.	EKG	659,608	5,252,679	0.125576	292,722	46,805	36,759	5,878
17.	EEG	1,896,475	5,114,912	0.370774	587,827	8,703	217,951	3,227
18.	Med. / Surg. Supplies	88,388,244	169,729,313	0.520760	6,961,675	1,439,879	3,625,362	749,831
19.	Drugs Charged to Patients	104,321,629	359,352,599	0.290304	13,281,244	2,466,438	3,855,598	716,017
20.	Renal Dialysis	13,043,269	38,588,509	0.338009	858,160	398,594	290,066	134,728
21.	Ambulance							
22.	Ultrasound	3,733,126	16,817,412	0.221980	676,231	360,911	150,110	80,115
23.	Radiology Angiography	7,065,842	66,242,070	0.106667	4,555,781	669,829	485,951	71,449
24.	Radiology W. Harrison	2,404,164	12,286,331	0.195678	4,069	298,521	796	58,414
25.	CT Scan	6,818,468	115,719,166	0.058923	4,505,695	2,099,064	265,489	123,683
26.	MRI	6,112,726	71,236,096	0.085809	2,334,536	1,491,524	200,324	127,986
27.	Cardiac Catheterization	3,096,152	23,460,353	0.131974	1,756,473	74,849	231,809	9,878
28.	Lab Tissue Typing	2,087,721	6,671,787	0.312918	41,814	84,051	13,084	26,301
29.	Lab Outreach	13,775,897	167,813,190	0.082091				
30.	Gastroenterology	8,932,984	34,506,532	0.258878	714,097	477,919	184,864	123,723
31.	Bone Marrow Transplant	3,035,478	4,036,307	0.752043	143,500	6,346	107,918	4,772
32.	Cardiac Services	8,030,411	33,664,764	0.238541	1,085,674	360,154	258,978	85,911
33.	Kidney Acquisition	16,698,332	23,491,526	0.710824	401,756		285,578	
34.	Liver Acquisition	4,340,688	8,651,852	0.501706	1,123,345		563,589	
35.	Pancreas Acquisition	1,525,922	3,907,288	0.390532				
36.	Other Organ Acquisition	696,497	203,036	3.430411				
37.	Radio Mile Square	929,295	3,283,633	0.283008				
38.	Telemedicine Prgm	4,115,800	1,631,343	2.522952				
39.	Sleep Lab West Harr	1,939,650	4,890,817	0.396590		168,720		66,913
40.	Sickle Cell Clinic	2,697,116	5,974,963	0.451403	107,546	86,151	48,547	38,889
41.	Heart Ctr	233,775	575,376	0.406300		7,115		2,891
42.	Hyperbarid Oxygen Ther.	205,179	191,224	1.072977				
Outpatient Service Cost Centers								
43.	Clinic	127,631,316	155,179,085	0.822478	24,299	5,902,593	19,985	4,854,753
44.	Emergency	32,133,680	112,158,010	0.286504	3,016,344	3,670,128	864,195	1,051,506
45.	Observation	13,058,635	17,854,894	0.731376	61,988	893,191	45,337	653,258
46.	Total				82,614,874	38,641,900	21,847,092	13,096,389

* 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: 07/01/2019 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)	175,418,619	27,625,245		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,339	12,415		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,359.71	2,225.15		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,003			
3.	Program general inpatient routine cost (Line 1c X Line 2)	9,445,919			
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)	9,445,919			

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	47,558,977	13,571	3,504.46	820	2,873,657
9.	Coronary Care Unit	26,440,710	6,384	4,141.72	390	1,615,271
10.	Pediatric ICU	8,173,248	1,315	6,215.40	231	1,435,757
11.	Neonatal ICU	28,518,864	9,721	2,933.74	3,357	9,848,565
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,094,088	2,890	1,070.62	1,398	1,496,727
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					21,847,092
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					48,562,988

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: 07/01/2019 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.	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)	
		(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:		Medicaid Provider Number:	
14-0150		3098	
Program:		Period Covered by Statement:	
Medicaid-Hospital		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.	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

BHF Page 6(b)

PRELIMINARY

Medicare Provider Number:	14-0150	Medicaid Provider Number:	3098
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.	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: 07/01/2019 To: 06/30/2020	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		13,096,389
2.	Inpatient Operating Services (BHF Page 4, Line 25)	48,562,988	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	5,074,678	1,372,411
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	53,637,666	14,468,800
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	79.00%	21.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	82,614,874	38,641,900
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	16,291,106	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	6,213,820	
	F. Coronary Care Unit	2,572,889	
	G. Pediatric ICU	1,885,635	
	H. Neonatal ICU	10,626,923	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	831,192	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	121,036,439	38,641,900
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		91,571,873
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: 07/01/2019 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)	53,637,666	14,468,800
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	53,637,666	14,468,800
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)	53,637,666	14,468,800

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:	14-0150	Medicaid Provider Number:	3098
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)	91,571,873
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: 14-0150	Medicaid Provider Number: 3098
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:	
14-0150		3098	
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	11,721,429	172,890,310	0.067797	4,385,181	3,204,428	297,302	217,251
2.	Recovery Room	109,503	13,394,859	0.008175	231,113	300,245	1,889	2,455
3.	Delivery and Labor Room	1,783,456	44,843,677	0.039771	4,758,566	693,228	189,253	27,570
4.	Anesthesiology	2,918,084	78,477,975	0.037183	3,577,358	1,229,459	133,017	45,715
5.	Radiology - Diagnostic	310,294	37,956,422	0.008175	991,925	758,009	8,109	6,197
6.	Radiology - Therapeutic	3,095,250	22,254,667	0.139083	167,044	715,613	23,233	99,530
7.	Nuclear Medicine	363,367	5,501,120	0.066053	167,211	128,674	11,045	8,499
8.	Laboratory	12,880,827	408,297,122	0.031548	14,585,739	9,585,456	460,151	302,402
9.	Blood							
10.	Blood - Administration	2,294,192	45,003,045	0.050979	3,131,653	419,277	159,649	21,374
11.	Intravenous Therapy	37,702	4,611,864	0.008175	307,489	11,952	2,514	98
12.	Respiratory Therapy	2,521,697	53,358,624	0.047259	6,504,746	122,458	307,408	5,787
13.	Physical Therapy	637,957	24,484,769	0.026055	603,531	266,271	15,725	6,938
14.	Occupational Therapy	307,953	9,433,080	0.032646	543,945	96,815	17,758	3,161
15.	Speech Pathology	257,457	4,229,962	0.060865	124,597	98,530	7,584	5,997
16.	EKG	695,652	5,252,679	0.132438	292,722	46,805	38,768	6,199
17.	EEG	41,814	5,114,912	0.008175	587,827	8,703	4,805	71
18.	Med. / Surg. Supplies	4,149,617	169,729,313	0.024448	6,961,675	1,439,879	170,199	35,202
19.	Drugs Charged to Patients	15,554,123	359,352,599	0.043284	13,281,244	2,466,438	574,865	106,757
20.	Renal Dialysis	1,747,404	38,588,509	0.045283	858,160	398,594	38,860	18,050
21.	Ambulance							
22.	Ultrasound	431,998	16,817,412	0.025688	676,231	360,911	17,371	9,271
23.	Radiology Angiography	2,905,615	66,242,070	0.043864	4,555,781	669,829	199,835	29,381
24.	Radiology W. Harrison	100,441	12,286,331	0.008175	4,069	298,521	33	2,440
25.	CT Scan	2,323,064	115,719,166	0.020075	4,505,695	2,099,064	90,452	42,139
26.	MRI	1,927,576	71,236,096	0.027059	2,334,536	1,491,524	63,170	40,359
27.	Cardiac Catheterization	3,089,186	23,460,353	0.131677	1,756,473	74,849	231,287	9,856
28.	Lab Tissue Typing	54,542	6,671,787	0.008175	41,814	84,051	342	687
29.	Lab Outreach	1,371,873	167,813,190	0.008175				
30.	Gastroenterology	282,091	34,506,532	0.008175	714,097	477,919	5,838	3,907
31.	Bone Marrow Transplant	32,997	4,036,307	0.008175	143,500	6,346	1,173	52
32.	Cardiac Services	275,209	33,664,764	0.008175	1,085,674	360,154	8,875	2,944
33.	Kidney Acquisition	574,117	23,491,526	0.024439	401,756		9,819	
34.	Liver Acquisition	420,964	8,651,852	0.048656	1,123,345		54,657	
35.	Pancreas Acquisition	31,942	3,907,288	0.008175				
36.	Other Organ Acquisition	81,259	203,036	0.400220				
37.	Radio Mile Square	26,844	3,283,633	0.008175				
38.	Telemedicine Prgm	13,336	1,631,343	0.008175				
39.	Sleep Lab West Harr	39,982	4,890,817	0.008175		168,720		1,379
40.	Sickle Cell Clinic	48,845	5,974,963	0.008175	107,546	86,151	879	704
41.	Heart Ctr	4,704	575,376	0.008176		7,115		58
42.	Hyperbaric Oxygen Ther.	1,563	191,224	0.008174				
	Outpatient Ancillary Centers							
43.	Clinic	5,367,929	155,179,085	0.034592	24,299	5,902,593	841	204,182
44.	Emergency	3,233,218	112,158,010	0.028827	3,016,344	3,670,128	86,952	105,799
45.	Observation							
46.	Ancillary Total						3,233,658	1,372,411

* 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: 07/01/2019 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	9,341,680	74,339	125.66	4,003		503,017	
48.	Psych	1,294,657	12,415	104.28				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,761,131	13,571	129.77	820		106,411	
52.	Coronary Care Unit	1,361,160	6,384	213.21	390		83,152	
53.	Pediatric ICU	726,704	1,315	552.63	231		127,658	
54.	Neonatal ICU	2,663,602	9,721	274.00	3,357		919,818	
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	208,727	2,890	72.22	1,398		100,964	
67.	Routine Total (lines 47-66)						1,841,020	
68.	Ancillary Total (from line 46)						3,233,658	1,372,411
69.	Total (Lines 67-68)						5,074,678	1,372,411

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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	8,801		8,801
Newborn Days	1,398		1,398
Total Inpatient Revenue	121,036,440	(1)	121,036,439
Ancillary Revenue	82,614,875	(1)	82,614,874
Routine Revenue	38,421,565		38,421,565
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	135,987		135,987
Total Outpatient Revenue	38,641,900		38,641,900
Outpatient Received and Receivable			

Notes:

BHF Page 2, Part I, Col 2 - Changed Bed Days Available to agree with Medicare W/S S-3 col 2 .
(facility originally did not consider 366 day year).

Reclassified Blood charges as Blood Admin.

BHF Page 3, Column 1 Costs were adjusted to filed W/S C, Pt 1, Col 1. Provider combined W/S Col 1 amts with
W/S B, Part 1, Col 25 amts

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

BHF Page 3 -Clinic costs and charges include Medicare lines 90, 93.01, 93.02, 93.03, and 93.04.

BHF Page 3 - Physical Therapy costs and charges include Medicare lines 66, 66.01, 66.02, 66.03

BHF Page 3 - Occupational Therapy costs and charges include Medicare lines 67 and 67.01