

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

Name of Hospital: Northwestern Memorial Hospital		Medicare Provider Number: 14-0281	
Street: 251 E. Huron		Medicaid Provider Number: 3122	
City: Chicago	State: Illinois	Zip: 60611	
Period Covered by Statement:	From: 09/01/2019	To: 08/31/2020	

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)) Northwestern Memorial Hospi 3122 for the cost report beginning 09/01/2019 and ending 08/31/2020 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

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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	673	247,375		201,893	81.61%		41,891	5.93
2.	Psych	29	10,614		9,227	86.93%		765	12.06
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	115	42,090		27,022	64.20%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,476		19,497	61.94%			
8.	Other								
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	114	41,724		23,342	55.94%			
22.	Total	1,017	373,279		280,981	75.27%		42,656	6.04
23.	Observation Bed Days				13,879				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,586			3,111	3.67
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,726				
6.	Coronary Care Unit								
7.	Special Care Nursery				2,117				
8.	Other								
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				1,138				
22.	Total				12,567	4.47%		3,111	3.67

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

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7)
1.	Operating Room	121,352,620	#####	0.100313	19,410,000		1,947,075	
2.	Recovery Room	13,908,755	60,576,057	0.229608	959,965		220,416	
3.	Delivery and Labor Room	40,713,595	206,771,964	0.196901	2,318,340		456,483	
4.	Anesthesiology	8,668,718	171,455,962	0.050559	3,029,257		153,156	
5.	Radiology - Diagnostic	62,260,163	425,732,288	0.146243	3,538,151		517,430	
6.	Radiology - Therapeutic	22,376,093	224,259,411	0.099778	509,232		50,810	
7.	Nuclear Medicine	22,850,799	87,943,830	0.259834	248,530		64,577	
8.	Laboratory	106,324,482	982,424,051	0.108227	16,561,441		1,792,395	
9.	Blood							
10.	Blood - Administration	10,579,408	38,470,721	0.274999	1,879,407		516,835	
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,176,799	105,512,031	0.210183	5,057,055		1,062,907	
13.	Physical Therapy	7,014,580	22,936,476	0.305826	635,494		194,351	
14.	Occupational Therapy	3,901,939	12,452,698	0.313341	805,862		252,510	
15.	Speech Pathology							
16.	EKG							
17.	EEG	8,571,766	62,286,230	0.137619	1,108,814		152,594	
18.	Med. / Surg. Supplies	61,445,689	296,295,003	0.207380	10,590,516		2,196,261	
19.	Drugs Charged to Patients	161,566,323	530,838,692	0.304360	11,659,733		3,548,756	
20.	Renal Dialysis	5,782,242	28,675,537	0.201644	1,415,877		285,503	
21.	Ambulance							
22.	Cardiac Cath Lab	5,468,825	85,430,660	0.064015	1,199,160		76,764	
23.	Cardiology Graphics	11,234,138	206,198,200	0.054482	2,932,019		159,742	
24.	Pulmonary Function Testing	1,617,281	12,557,580	0.128789	2,866,452		369,167	
25.	MRI	22,663,980	295,149,827	0.076788	2,095,580		160,915	
26.	Vascular Lab	2,092,053	36,158,994	0.057857	589,457		34,104	
27.	EPS	2,871,727	42,681,439	0.067283				
28.	CT Scan	16,251,464	402,873,881	0.040339	5,034,825		203,100	
29.	GI Lab	19,759,200	142,878,696	0.138294	502,395		69,478	
30.	Transplant Clinic	6,014,419	6,015,710	0.999785				
31.	Transplant Acq (Liver/Kidney/Heart/Pa	33,696,866	46,648,058	0.722364	227,155		164,089	
32.	OB & Psych Clinic	4,298,250	930,428	4.619648				
33.	Blood Flow Lab	18,493,783	53,040,089	0.348676				
34.	Implantable Devices	98,308,389	302,289,629	0.325213	1,712,836		557,037	
35.	Observation - Non Distinct	21,597,112	62,741,523	0.344224	4,858,685		1,672,476	
36.	Med Therapy Mgmt	752,780						
37.	Cardiac Rehab	659,197	2,649,029	0.248845				
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	24,590,203	30,536,455	0.805274	156,379		125,928	
44.	Emergency	39,746,571	332,517,229	0.119532	1,505,463		179,951	
45.	Observation - Distinct	8,643,315	15,315,461	0.564352				
46.	Total				103,408,080		17,184,810	

* 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

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2019 To: 08/31/2020

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)	334,211,673	11,299,659		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	215,772	9,227		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,548.91	1,224.63		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,586			
3.	Program general inpatient routine cost (Line 1c X Line 2)	11,750,031			
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)	11,750,031			

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	85,553,317	27,022	3,166.06	1,726	5,464,620
9.	Coronary Care Unit					
10.	Special Care Nursery	31,970,544	19,497	1,639.77	2,117	3,471,393
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	9,025,997	23,342	386.68	1,138	440,042
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					17,184,810
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					38,310,896

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

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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.	Special Care Nursery						
9.	Other						
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	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation - Distinct								
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)

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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.	Cardiac Cath Lab							
23.	Cardiology Graphics							
24.	Pulmonary Function Testing							
25.	MRI							
26.	Vascular Lab							
27.	EPS							
28.	CT Scan							
29.	GI Lab							
30.	Transplant Clinic							
31.	Transplant Acq (Liver/Kidney/Heart/Par							
32.	OB & Psych Clinic							
33.	Blood Flow Lab							
34.	Implantable Devices							
35.	Observation - Non Distinct							
36.	Med Therapy Mgmt							
37.	Cardiac Rehab							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation - Distinct							
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)

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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.	Special Care Nursery							
54.	Other							
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

Medicare Provider Number: 14-0281		Medicaid Provider Number: 3122	
Program: Medicaid-Hospital		Period Covered by Statement: From: 09/01/2019 To: 08/31/2020	
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)	38,310,896	
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)	1,935,074	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	40,245,970	
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)	103,408,080	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	16,208,999	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	10,517,327	
	F. Coronary Care Unit		
	G. Special Care Nursery	17,382,311	
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,906,647	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	149,423,364	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		109,177,394
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

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2019 To: 08/31/2020

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)	40,245,970	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	40,245,970	
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)	40,245,970	

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.

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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)	109,177,394
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

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2019 To: 08/31/2020

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)

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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	19,373,515	#####	0.016015	19,410,000		310,851	
2.	Recovery Room	897,648	60,576,057	0.014819	959,965		14,226	
3.	Delivery and Labor Room	3,198,416	206,771,964	0.015468	2,318,340		35,860	
4.	Anesthesiology	130,725	171,455,962	0.000762	3,029,257		2,308	
5.	Radiology - Diagnostic	5,873,932	425,732,288	0.013797	3,538,151		48,816	
6.	Radiology - Therapeutic	1,873,732	224,259,411	0.008355	509,232		4,255	
7.	Nuclear Medicine	252,736	87,943,830	0.002874	248,530		714	
8.	Laboratory	4,784,552	982,424,051	0.004870	16,561,441		80,654	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	252,736	105,512,031	0.002395	5,057,055		12,112	
13.	Physical Therapy	17,430	22,936,476	0.000760	635,494		483	
14.	Occupational Therapy	26,145	12,452,698	0.002100	805,862		1,692	
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	209,161	296,295,003	0.000706	10,590,516		7,477	
19.	Drugs Charged to Patients	8,715	530,838,692	0.000016	11,659,733		187	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	505,472	85,430,660	0.005917	1,199,160		7,095	
23.	Cardiology Graphics	775,638	206,198,200	0.003762	2,932,019		11,030	
24.	Pulmonary Function Testing	287,596	12,557,580	0.022902	2,866,452		65,647	
25.	MRI							
26.	Vascular Lab							
27.	EPS							
28.	CT Scan							
29.	GI Lab	488,042	142,878,696	0.003416	502,395		1,716	
30.	Transplant Clinic	435,751	6,015,710	0.072436				
31.	Transplant Acq (Liver/Kidney/Heart/P							
32.	OB & Psych Clinic	435,751	930,428	0.468334				
33.	Blood Flow Lab	366,032	53,040,089	0.006901				
34.	Implantable Devices							
35.	Observation - Non Distinct							
36.	Med Therapy Mgmt							
37.	Cardiac Rehab							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	2,858,531	30,536,455	0.093610	156,379		14,639	
44.	Emergency	2,666,799	332,517,229	0.008020	1,505,463		12,074	
45.	Observation - Distinct							
46.	Ancillary Total						631,836	

* 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)

Medicare Provider Number:	14-0281	Medicaid Provider Number:	3122
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 09/01/2019 To: 08/31/2020

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	20,114,293	215,772	93.22	7,586		707,167	
48.	Psych	2,361,774	9,227	255.96				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	8,532,016	27,022	315.74	1,726		544,967	
52.	Coronary Care Unit							
53.	Special Care Nursery	470,612	19,497	24.14	2,117		51,104	
54.	Other							
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)						1,303,238	
68.	Ancillary Total (from line 46)						631,836	
69.	Total (Lines 67-68)						1,935,074	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Medicare Provider Number: 14-0281	Medicaid Provider Number: 3122
Program: Medicaid-Hospital	Period Covered by Statement: From: 09/01/2019 To: 08/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	11,429		11,429
Newborn Days	1,138		1,138
Total Inpatient Revenue	149,423,364		149,423,364
Ancillary Revenue	103,408,080		103,408,080
Routine Revenue	46,015,284		46,015,284
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Page 2, Part 1 A&P days available and days adjusted to tie to Medicare rpt

Page 2, Observation Bed Days changed to tie to Medicare rpt.

Blood on BHF Page 3 is reclassified as Blood Flow Lab to agree with prior year.

Included Observation Beds (Non-Distinct)