

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								
2.	Psych				3,848			129	29.83
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU								
8.	Neonatal ICU								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				3,848	3.34%		129	29.83

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
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) (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	55,066,878	172,890,310	0.318508	237		75	
2.	Recovery Room	10,884,408	13,394,859	0.812581	25,955		21,091	
3.	Delivery and Labor Room	27,566,614	44,843,677	0.614727	13,921		8,558	
4.	Anesthesiology	4,881,401	78,477,975	0.062201	2,369		147	
5.	Radiology - Diagnostic	17,389,854	37,956,422	0.458153	18,431		8,444	
6.	Radiology - Therapeutic	8,640,659	22,254,667	0.388263				
7.	Nuclear Medicine	1,724,055	5,501,120	0.313401				
8.	Laboratory	52,954,850	408,297,122	0.129697	420,133		54,490	
9.	Blood							
10.	Blood - Administration	9,528,121	45,003,045	0.211722	2,091		443	
11.	Intravenous Therapy	1,146,801	4,611,864	0.248663				
12.	Respiratory Therapy	10,353,687	53,358,624	0.194040	45,939		8,914	
13.	Physical Therapy	18,155,657	24,484,769	0.741508	3,888		2,883	
14.	Occupational Therapy	6,745,283	9,433,080	0.715067	485,268		346,999	
15.	Speech Pathology	2,069,275	4,229,962	0.489195	1,752		857	
16.	EKG	659,608	5,252,679	0.125576	19,754		2,481	
17.	EEG	1,896,475	5,114,912	0.370774	8,626		3,198	
18.	Med. / Surg. Supplies	88,388,244	169,729,313	0.520760	116,865		60,859	
19.	Drugs Charged to Patients	104,321,629	359,352,599	0.290304	677,875		196,790	
20.	Renal Dialysis	13,043,269	38,588,509	0.338009				
21.	Ambulance							
22.	Ultrasound	3,733,126	16,817,412	0.221980	5,362		1,190	
23.	Radiology Angiography	7,065,842	66,242,070	0.106667				
24.	Radiology W. Harrison	2,404,164	12,286,331	0.195678				
25.	CT Scan	6,818,468	115,719,166	0.058923	47,155		2,779	
26.	MRI	6,112,726	71,236,096	0.085809	67,184		5,765	
27.	Cardiac Catheterization	3,096,152	23,460,353	0.131974				
28.	Lab Tissue Typing	2,087,721	6,671,787	0.312918				
29.	Lab Outreach	13,775,897	167,813,190	0.082091				
30.	Gastroenterology	8,932,984	34,506,532	0.258878	3,970		1,028	
31.	Bone Marrow Transplant	3,035,478	4,036,307	0.752043				
32.	Cardiac Services	8,030,411	33,664,764	0.238541	6,777		1,617	
33.	Kidney Acquisition	16,698,332	23,491,526	0.710824				
34.	Liver Acquisition	4,340,688	8,651,852	0.501706				
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				
40.	Sickle Cell Clinic	2,697,116	5,974,963	0.451403				
41.	Heart Ctr	233,775	575,376	0.406300				
42.	Hyperbarid Oxygen Ther.	205,179	191,224	1.072977				
Outpatient Service Cost Centers								
43.	Clinic	127,631,316	155,179,085	0.822478				
44.	Emergency	32,133,680	112,158,010	0.286504	204,813		58,680	
45.	Observation	13,058,635	17,854,894	0.731376				
46.	Total				2,178,365		787,288	

* 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)		3,848		
3.	Program general inpatient routine cost (Line 1c X Line 2)		8,562,377		
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)		8,562,377		

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		
9.	Coronary Care Unit	26,440,710	6,384	4,141.72		
10.	Pediatric ICU	8,173,248	1,315	6,215.40		
11.	Neonatal ICU	28,518,864	9,721	2,933.74		
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		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					787,288
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					9,349,665

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	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

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)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	9,349,665	
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)	477,651	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	9,827,316	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	2,178,365	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	8,012,164	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Pediatric ICU		
	H. Neonatal ICU		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	10,190,529	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		363,213
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)	9,827,316	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	9,827,316	
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)	9,827,316	

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)	363,213
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:	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 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	237		16	
2.	Recovery Room	109,503	13,394,859	0.008175	25,955		212	
3.	Delivery and Labor Room	1,783,456	44,843,677	0.039771	13,921		554	
4.	Anesthesiology	2,918,084	78,477,975	0.037183	2,369		88	
5.	Radiology - Diagnostic	310,294	37,956,422	0.008175	18,431		151	
6.	Radiology - Therapeutic	3,095,250	22,254,667	0.139083				
7.	Nuclear Medicine	363,367	5,501,120	0.066053				
8.	Laboratory	12,880,827	408,297,122	0.031548	420,133		13,254	
9.	Blood							
10.	Blood - Administration	2,294,192	45,003,045	0.050979	2,091		107	
11.	Intravenous Therapy	37,702	4,611,864	0.008175				
12.	Respiratory Therapy	2,521,697	53,358,624	0.047259	45,939		2,171	
13.	Physical Therapy	637,957	24,484,769	0.026055	3,888		101	
14.	Occupational Therapy	307,953	9,433,080	0.032646	485,268		15,842	
15.	Speech Pathology	257,457	4,229,962	0.060865	1,752		107	
16.	EKG	695,652	5,252,679	0.132438	19,754		2,616	
17.	EEG	41,814	5,114,912	0.008175	8,626		71	
18.	Med. / Surg. Supplies	4,149,617	169,729,313	0.024448	116,865		2,857	
19.	Drugs Charged to Patients	15,554,123	359,352,599	0.043284	677,875		29,341	
20.	Renal Dialysis	1,747,404	38,588,509	0.045283				
21.	Ambulance							
22.	Ultrasound	431,998	16,817,412	0.025688	5,362		138	
23.	Radiology Angiography	2,905,615	66,242,070	0.043864				
24.	Radiology W. Harrison	100,441	12,286,331	0.008175				
25.	CT Scan	2,323,064	115,719,166	0.020075	47,155		947	
26.	MRI	1,927,576	71,236,096	0.027059	67,184		1,818	
27.	Cardiac Catheterization	3,089,186	23,460,353	0.131677				
28.	Lab Tissue Typing	54,542	6,671,787	0.008175				
29.	Lab Outreach	1,371,873	167,813,190	0.008175				
30.	Gastroenterology	282,091	34,506,532	0.008175	3,970		32	
31.	Bone Marrow Transplant	32,997	4,036,307	0.008175				
32.	Cardiac Services	275,209	33,664,764	0.008175	6,777		55	
33.	Kidney Acquisition	574,117	23,491,526	0.024439				
34.	Liver Acquisition	420,964	8,651,852	0.048656				
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				
40.	Sickle Cell Clinic	48,845	5,974,963	0.008175				
41.	Heart Ctr	4,704	575,376	0.008176				
42.	Hyperbaric Oxygen Ther.	1,563	191,224	0.008174				
	Outpatient Ancillary Centers							
43.	Clinic	5,367,929	155,179,085	0.034592				
44.	Emergency	3,233,218	112,158,010	0.028827	204,813		5,904	
45.	Observation							
46.	Ancillary Total						76,382	

* 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				
48.	Psych	1,294,657	12,415	104.28	3,848		401,269	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,761,131	13,571	129.77				
52.	Coronary Care Unit	1,361,160	6,384	213.21				
53.	Pediatric ICU	726,704	1,315	552.63				
54.	Neonatal ICU	2,663,602	9,721	274.00				
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				
67.	Routine Total (lines 47-66)						401,269	
68.	Ancillary Total (from line 46)						76,382	
69.	Total (Lines 67-68)						477,651	

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	3,848		3,848
Newborn Days			
Total Inpatient Revenue	10,190,529		10,190,529
Ancillary Revenue	2,178,365		2,178,365
Routine Revenue	8,012,164		8,012,164
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service	135,987		135,987
Total Outpatient Revenue			
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