

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: Rush University Children's		Medicare Provider Number: 14-0119	
Street: 1653 W Congress Pkwy		Medicaid Provider Number: 3047	
City: Chicago	State: Illinois	Zip: 60612	
Period Covered by Statement:	From: 07/01/2020	To: 06/30/2021	

Type of Control

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

Type of Hospital

☒ XXXX XXXX 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)

☒ XXXX XXXX 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)) Rush University Children's 3047 for the cost report beginning 07/01/2020 and ending 06/30/2021 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:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	20	7,300		3,451	47.27%		1,997	10.16
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Medical ICU								
8.	Surgical ICU								
9.	Pediatric ICU	18	6,013		2,826	47.00%			
10.	Premature ICU	60	21,900		14,014	63.99%			
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				3,221				
22.	Total	98	35,213		23,512	66.77%		1,997	10.16
23.	Observation Bed Days				312				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				222			240	13.29
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Medical ICU								
8.	Surgical ICU								
9.	Pediatric ICU				588				
10.	Premature ICU				2,379				
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				518				
22.	Total				3,707	15.77%		240	13.29

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:	
14-0119		3047	
Program:		Period Covered by Statement:	
Medicaid-Hospital		From: 07/01/2020	To: 06/30/2021

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	70,894,010	409,695,325	0.173041	605,490		104,775	
2.	Recovery Room	13,810,943	43,352,017	0.318577	27,824		8,864	
3.	Delivery and Labor Room	12,502,282	23,840,303	0.524418	500		262	
4.	Anesthesiology	18,506,246	169,659,450	0.109079	244,364		26,655	
5.	Radiology - Diagnostic	58,677,083	443,455,465	0.132318	868,516		114,920	
6.	Radiology - Therapeutic	17,704,143	92,634,418	0.191118				
7.	Nuclear Medicine	4,748,532	18,155,588	0.261547	8,003		2,093	
8.	Laboratory	97,070,605	520,454,647	0.186511	2,005,178		373,988	
9.	Blood							
10.	Blood - Administration	13,267,648	43,516,524	0.304888	423,975		129,265	
11.	Intravenous Therapy	2,126,177	47,561,966	0.044703	21,959		982	
12.	Respiratory Therapy	15,605,837	51,678,793	0.301978	3,407,841		1,029,093	
13.	Physical Therapy	7,207,942	21,499,473	0.335261	129,896		43,549	
14.	Occupational Therapy	5,533,471	15,617,631	0.354309	24,004		8,505	
15.	Speech Pathology	3,226,875	9,685,363	0.333170	184,036		61,315	
16.	EKG	18,353,491	116,944,066	0.156942	433,773		68,077	
17.	EEG	3,830,422	23,465,894	0.163234	723,379		118,080	
18.	Med. / Surg. Supplies	47,440,349	141,676,758	0.334849	264,376		88,526	
19.	Drugs Charged to Patients	256,782,313	882,629,444	0.290929	2,448,024		712,201	
20.	Renal Dialysis							
21.	Ambulance							
22.	Implant Devices	93,563,865	264,083,160	0.354297				
23.	Renal Dialysis Adult	6,825,334	16,398,312	0.416222	26,106		10,866	
24.	Day Hospital	3,714,133	1,518,787	2.445460				
25.	Heart Acquisitions	106						
26.	Kidney Acquisitions	6,747,153	10,224,000	0.659933				
27.	Liver Acquisitions	4,040,515	4,635,000	0.871740				
28.	Pancreas Acquisitions	447,452	824,000	0.543024				
29.	Lab HLA	2,428,863	5,641,009	0.430572				
30.	Allogenic Stem Cell	3,627,480	3,567,977	1.016677				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	114,416,484	274,683,133	0.416540				
44.	Emergency	39,113,589	221,736,936	0.176396	6,649		1,173	
45.	Observation	12,626,522	55,475,085	0.227607	21,505		4,895	
46.	Total				11,875,398		2,908,084	

* 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: 14-0119	Medicaid Provider Number: 3047
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	4,821,251			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	3,763			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,281.23			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	222			
3.	Program general inpatient routine cost (Line 1c X Line 2)	284,433			
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)	284,433			

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					
9.	Coronary Care Unit					
10.	Medical ICU					
11.	Surgical ICU					
12.	Pediatric ICU	8,259,665	2,826	2,922.74	588	1,718,571
13.	Premature ICU	25,038,428	14,014	1,786.67	2,379	4,250,488
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,341,538	3,221	1,037.42	518	537,384
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,908,084
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					9,698,960

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

Medicare Provider Number:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	
		From:	To:
		07/01/2020	06/30/2021

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.	Medical ICU						
9.	Surgical ICU						
10.	Pediatric ICU						
11.	Premature ICU						
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:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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.	Implant Devices							
23.	Renal Dialysis Adult							
24.	Day Hospital							
25.	Heart Acquisitions							
26.	Kidney Acquisitions							
27.	Liver Acquisitions							
28.	Pancreas Acquisitions							
29.	Lab HLA							
30.	Allogenic Stem Cell							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
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:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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.	Medical ICU							
54.	Surgical ICU							
55.	Pediatric ICU							
56.	Premature ICU							
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: 14-0119	Medicaid Provider Number: 3047
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1. Ancillary Services (BHF Page 3, Line 46, Col. 7)			
2. Inpatient Operating Services (BHF Page 4, Line 25)		9,698,960	
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)		461,652	
7. Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)		10,160,612	
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	Program Outpatient
		(1)	(2)
9. Ancillary Services (See Instructions)		11,875,398	
10. Inpatient Routine Services (Provider's Records)			
A. Adults and Pediatrics		940,980	
B. Psych			
C. Rehab			
D. Other (Sub)			
E. Intensive Care Unit			
F. Coronary Care Unit			
G. Medical ICU			
H. Surgical ICU			
I. Pediatric ICU		2,492,326	
J. Premature ICU		10,083,747	
K. Other			
L. Other			
M. Other			
N. Other			
O. Other			
P. Other			
Q. Other			
R. Other			
S. Other			
T. Nursery		2,195,620	
11. Services of Teaching Physicians (Provider's Records)			
12. Total Charges for Patient Services (Sum of Lines 9 through 11)		27,588,071	
13. Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)			17,427,459
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: 14-0119	Medicaid Provider Number: 3047
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	10,160,612	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	10,160,612	
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)	10,160,612	

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:	Medicaid Provider Number:
14-0119	3047
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2020 To: 06/30/2021

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)	17,427,459
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(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: 14-0119	Medicaid Provider Number: 3047
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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

1.	Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	5,397,432	409,695,325	0.013174	605,490		7,977	
2.	Recovery Room							
3.	Delivery and Labor Room	798,151	23,840,303	0.033479	500		17	
4.	Anesthesiology	5,668,079	169,659,450	0.033409	244,364		8,164	
5.	Radiology - Diagnostic	6,055,949	443,455,465	0.013656	868,516		11,860	
6.	Radiology - Therapeutic	444,758	92,634,418	0.004801				
7.	Nuclear Medicine	892,964	18,155,588	0.049184	8,003		394	
8.	Laboratory	1,996,239	520,454,647	0.003836	2,005,178		7,692	
9.	Blood							
10.	Blood - Administration	225,827	43,516,524	0.005189	423,975		2,200	
11.	Intravenous Therapy							
12.	Respiratory Therapy	577,496	51,678,793	0.011175	3,407,841		38,083	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,079,142	116,944,066	0.009228	433,773		4,003	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implant Devices							
23.	Renal Dialysis Adult	1,213,603	16,398,312	0.074008	26,106		1,932	
24.	Day Hospital	2,723,712	1,518,787	1.793347				
25.	Heart Acquisitions							
26.	Kidney Acquisitions	172,387	10,224,000	0.016861				
27.	Liver Acquisitions							
28.	Pancreas Acquisitions							
29.	Lab HLA							
30.	Allogenic Stem Cell							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	9,812,258	274,683,133	0.035722				
44.	Emergency	5,771,512	221,736,936	0.026029	6,649		173	
45.	Observation							
46.	Ancillary Total						82,495	

* 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:	14-0119	Medicaid Provider Number:	3047
Program:	Medicaid-Hospital	Period Covered by Statement:	From: 07/01/2020 To: 06/30/2021

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	772,204	3,763	205.21	222		45,557	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Medical ICU							
54.	Surgical ICU							
55.	Pediatric ICU	705,062	2,826	249.49	588		146,700	
56.	Premature ICU	955,023	14,014	68.15	2,379		162,129	
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	154,040	3,221	47.82	518		24,771	
67.	Routine Total (lines 47-66)						379,157	
68.	Ancillary Total (from line 46)						82,495	
69.	Total (Lines 67-68)						461,652	

PRELIMINARY

Medicare Provider Number: 14-0119	Medicaid Provider Number: 3047
Program: Medicaid-Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	3,189		3,189
Newborn Days	518		518
Total Inpatient Revenue	27,588,071		27,588,071
Ancillary Revenue	11,875,398		11,875,398
Routine Revenue	15,712,673		15,712,673
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]