

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: 09/01/2020	To: 08/31/2021	

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 09/01/2020 and ending 08/31/2021 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

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: 09/01/2020 To: 08/31/2021

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	673	245,645		212,806	86.63%		41,891	6.42
2.	Psych	29	10,585		9,225	87.15%		759	12.15
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	115	41,975		37,004	88.16%			
6.	Coronary Care Unit								
7.	Special Care Nursery	86	31,390		19,044	60.67%			
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	41,610		23,862	57.35%			
22.	Total	1,017	371,205		301,941	81.34%		42,650	6.52
23.	Observation Bed Days				22,963				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,125			1,422	5.38
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,551				
6.	Coronary Care Unit								
7.	Special Care Nursery				970				
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				750				
22.	Total				8,396	2.78%		1,422	5.38

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: 09/01/2020 To: 08/31/2021

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	120,414,954	#####	0.075059	11,693,146		877,676	
2.	Recovery Room	15,439,879	78,162,028	0.197537	601,265		118,772	
3.	Delivery and Labor Room	42,327,653	231,650,379	0.182722	1,694,639		309,648	
4.	Anesthesiology	11,552,277	224,840,789	0.051380	1,894,499		97,339	
5.	Radiology - Diagnostic	61,452,495	491,165,064	0.125116	2,603,057		325,684	
6.	Radiology - Therapeutic	24,353,709	224,346,596	0.108554	225,933		24,526	
7.	Nuclear Medicine	24,639,089	107,016,805	0.230236	156,315		35,989	
8.	Laboratory	136,648,442	#####	0.101679	14,464,653		1,470,751	
9.	Blood							
10.	Blood - Administration	38,200,093	122,982,354	0.310614	2,695,292		837,195	
11.	Intravenous Therapy							
12.	Respiratory Therapy	23,810,354	117,116,668	0.203305	8,309,939		1,689,452	
13.	Physical Therapy	7,567,340	25,918,855	0.291963	663,397		193,687	
14.	Occupational Therapy	4,611,788	14,880,708	0.309917	334,319		103,611	
15.	Speech Pathology							
16.	EKG							
17.	EEG	9,048,152	68,385,355	0.132311	667,445		88,310	
18.	Med. / Surg. Supplies	84,679,760	368,604,195	0.229731	7,101,960		1,631,540	
19.	Drugs Charged to Patients	186,331,094	539,479,830	0.345390	7,726,524		2,668,664	
20.	Renal Dialysis	7,274,039	35,080,879	0.207351	1,005,214		208,432	
21.	Ambulance							
22.	Cardiac Cath Lab	6,102,755	122,597,631	0.049779	879,385		43,775	
23.	Cardiology	12,430,727	250,621,250	0.049600				
24.	Pulmonary Function Testing	1,694,920	10,163,837	0.166760				
25.	MRI	24,238,481	346,272,362	0.069998	1,325,562		92,787	
26.	Vascular Lab	2,323,331	45,148,301	0.051460				
27.	EPS							
28.	CT Scan	17,556,854	485,937,970	0.036130	3,870,609		139,845	
29.	GI Lab	21,050,450	200,612,045	0.104931	341,823		35,868	
30.	Transplant Clinic	7,315,011	6,270,239	1.166624				
31.	Transplant Acq (Liver/Kidney/Heart/Pa	43,993,122	63,872,960	0.688760				
32.	Psych Clinic	4,676,014	844,056	5.539933	12,600		69,803	
33.	Blood Flow Lab							
34.	Implantable Devices	113,967,159	338,229,045	0.336953				
35.	Observation - Non Distinct	34,006,596	86,341,493	0.393862	3,918,459		1,543,332	
36.	Med Therapy Mgmt	235,383						
37.	Cardiac Rehab	866,754	2,913,504	0.297495				
38.	COVID Clinic	1,925,071	13,320,050	0.144524				
39.	Electromyography	4,268,557	53,132,873	0.080337				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	25,334,493	37,784,320	0.670503	114,453		76,741	
44.	Emergency	39,557,175	324,281,887	0.121984	431,434		52,628	
45.	Observation - Distinct							
46.	Total				72,731,922		12,736,055	

* 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: 09/01/2020 To: 08/31/2021

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)	347,855,502	11,414,232		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	235,769	9,225		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,475.41	1,237.32		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,125			
3.	Program general inpatient routine cost (Line 1c X Line 2)	7,561,476			
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)	7,561,476			

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	105,081,749	37,004	2,839.74	1,551	4,404,437
9.	Coronary Care Unit					
10.	Special Care Nursery	31,820,822	19,044	1,670.91	970	1,620,783
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	11,111,491	23,862	465.66	750	349,245
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					12,736,055
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					26,671,996

**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: 09/01/2020 To: 08/31/2021

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.	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: 09/01/2020 To: 08/31/2021

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.	Cardiac Cath Lab							
23.	Cardiology							
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.	Psych Clinic							
33.	Blood Flow Lab							
34.	Implantable Devices							
35.	Observation - Non Distinct							
36.	Med Therapy Mgmt							
37.	Cardiac Rehab							
38.	COVID Clinic							
39.	Electromyography							
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: 09/01/2020 To: 08/31/2021

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.	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: 09/01/2020 To: 08/31/2021	
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)	26,671,996	
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)	1,061,835	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	27,733,831	
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)	72,731,922	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	22,428,822	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,900,060	
	F. Coronary Care Unit		
	G. Special Care Nursery	2,007,154	
	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	2,514,950	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	103,582,908	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		75,849,077
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: 09/01/2020 To: 08/31/2021

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)	27,733,831	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	27,733,831	
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)	27,733,831	

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: 09/01/2020 To: 08/31/2021

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)	75,849,077
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: 09/01/2020 To: 08/31/2021

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

	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: 09/01/2020 To: 08/31/2021

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	18,194,968	#####	0.011342	11,693,146		132,624	
2.	Recovery Room	843,041	78,162,028	0.010786	601,265		6,485	
3.	Delivery and Labor Room	3,003,848	231,650,379	0.012967	1,694,639		21,974	
4.	Anesthesiology	122,773	224,840,789	0.000546	1,894,499		1,034	
5.	Radiology - Diagnostic	5,516,603	491,165,064	0.011232	2,603,057		29,238	
6.	Radiology - Therapeutic	1,759,747	224,346,596	0.007844	225,933		1,772	
7.	Nuclear Medicine	237,362	107,016,805	0.002218	156,315		347	
8.	Laboratory	4,493,494	#####	0.003344	14,464,653		48,370	
9.	Blood							
10.	Blood - Administration	343,765	122,982,354	0.002795	2,695,292		7,533	
11.	Intravenous Therapy							
12.	Respiratory Therapy	237,362	117,116,668	0.002027	8,309,939		16,844	
13.	Physical Therapy	16,370	25,918,855	0.000632	663,397		419	
14.	Occupational Therapy	24,555	14,880,708	0.001650	334,319		552	
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	196,437	368,604,195	0.000533	7,101,960		3,785	
19.	Drugs Charged to Patients	8,185	539,479,830	0.000015	7,726,524		116	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	474,722	122,597,631	0.003872	879,385		3,405	
23.	Cardiology	728,453	250,621,250	0.002907				
24.	Pulmonary Function Testing	270,101	10,163,837	0.026575				
25.	MRI							
26.	Vascular Lab							
27.	EPS							
28.	CT Scan							
29.	GI Lab	458,352	200,612,045	0.002285	341,823		781	
30.	Transplant Clinic	409,243	6,270,239	0.065268				
31.	Transplant Acq (Liver/Kidney/Heart/P							
32.	Psych Clinic	409,243	844,056	0.484853	12,600		6,109	
33.	Blood Flow Lab							
34.	Implantable Devices							
35.	Observation - Non Distinct							
36.	Med Therapy Mgmt							
37.	Cardiac Rehab							
38.	COVID Clinic							
39.	Electromyography							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	2,684,638	37,784,320	0.071052	114,453		8,132	
44.	Emergency	2,504,570	324,281,887	0.007723	431,434		3,332	
45.	Observation - Distinct							
46.	Ancillary Total						292,852	

* 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: 09/01/2020 To: 08/31/2021

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	18,890,681	235,769	80.12	5,125		410,615	
48.	Psych	2,218,100	9,225	240.44				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	8,012,989	37,004	216.54	1,551		335,854	
52.	Coronary Care Unit							
53.	Special Care Nursery	441,983	19,044	23.21	970		22,514	
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)						768,983	
68.	Ancillary Total (from line 46)						292,852	
69.	Total (Lines 67-68)						1,061,835	

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: 09/01/2020 To: 08/31/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,646		7,646
Newborn Days	750		750
Total Inpatient Revenue	103,582,908		103,582,908
Ancillary Revenue	72,731,922		72,731,922
Routine Revenue	30,850,986		30,850,986
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]