

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 Chicago - Comer Children's Hospital	Medicare Provider Number: 14-0088	
Street: 5841 South Maryland Avenue	Medicaid Provider Number: 3466	
City: Chicago	State: Illinois	Zip: 60637-1424
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 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)) University of Chicago - Comer 3466 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
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: 14-0088				Medicaid Provider Number: 3466			
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	60	21,900		19,055	87.01%		4,361	9.17
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	19	6,935		4,711	67.93%			
6.	Coronary Care Unit	9	3,285		1,162	35.37%			
7.	Burn ICU								
8.	Nursery Special Care								
9.	Nursery ICU	53	19,345		15,058	77.84%			
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	141	51,465		39,986	77.70%		4,361	9.17
23.	Observation Bed Days				2,611				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,048			1,283	3.71
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				878				
6.	Coronary Care Unit				76				
7.	Burn ICU								
8.	Nursery Special Care								
9.	Nursery ICU				2,762				
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				4,764	11.91%		1,283	3.71

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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	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) (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	95,794,519	699,617,364	0.136924	4,003,682		548,200	
2.	Recovery Room	30,885,851	107,696,283	0.286787				
3.	Delivery and Labor Room	18,424,663	56,933,285	0.323618	50,637		16,387	
4.	Anesthesiology	13,072,450	310,949,787	0.042040	1,025,436		43,109	
5.	Radiology - Diagnostic	50,168,577	318,191,755	0.157668	1,565,298		246,797	
6.	Radiology - Therapeutic	28,483,806	227,493,462	0.125207	35,324		4,423	
7.	Nuclear Medicine							
8.	Laboratory	72,207,513	#####	0.054671	6,572,853		359,344	
9.	Blood							
10.	Blood - Administration	24,908,434	163,408,552	0.152430	966,290		147,292	
11.	Intravenous Therapy							
12.	Respiratory Therapy	24,608,196	163,646,571	0.150374	10,398,555		1,563,672	
13.	Physical Therapy	12,786,030	54,820,805	0.233233	345,029		80,472	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	20,639,588	274,464,487	0.075199	1,626,837		122,337	
17.	EEG	7,722,719	35,478,857	0.217671	391,933		85,312	
18.	Med. / Surg. Supplies	49,635,202	210,829,457	0.235428				
19.	Drugs Charged to Patients	229,712,989	#####	0.150687				
20.	Renal Dialysis	7,072,934	48,146,066	0.146906	104,014		15,280	
21.	Ambulance	2,226,324	4,523	492.222861				
22.	CT Scan	11,235,664	535,486,236	0.020982	610,740		12,815	
23.	MRI	9,786,271	198,812,564	0.049224	512,351		25,220	
24.	Cardiac Cath	10,299,699	103,359,394	0.099649				
25.	Brace & Plaster Room	316,778	1,083,499	0.292366				
26.	Implants	66,351,973	303,193,582	0.218844				
27.	Cardiac Rehab	280,299	2,437,539	0.114993				
28.	Kidney Acquisition	9,461,261	19,511,572	0.484905	293,720		142,426	
29.	Heart Acquisition	5,251,794	10,583,958	0.496203				
30.	Liver Acquisition	6,827,155	13,591,821	0.502299				
31.	Lung Acquisition	3,454,944	7,639,148	0.452268				
32.	Pancreas Acquisition	658,678	1,182,519	0.557013				
33.	Islet Acquisition							
34.	Ultra Sound							
35.	Allogeneic	4,322,105	8,348,424	0.517715				
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics	45,169,862	354,456,865	0.127434				
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	181,502,480	603,805,081	0.300598	861,920		259,091	
44.	Emergency	100,876,817	390,067,531	0.258614	1,578,822		408,305	
45.	Observation	23,261,760	75,052,792	0.309939				
46.	Total				30,943,441		4,080,482	

* 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: 14-0088	Medicaid Provider Number: 3466
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)	33,953,980			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	21,666			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,567.15			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,048			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,642,373			
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)	1,642,373			

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	14,641,132	4,711	3,107.86	878	2,728,701
9.	Coronary Care Unit	2,876,893	1,162	2,475.81	76	188,162
10.	Burn ICU					
11.	Nursery Special Care					
12.	Nursery ICU	36,860,104	15,058	2,447.88	2,762	6,761,045
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					4,080,482
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					15,400,763

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

Preliminary

Medicare Provider Number:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2020 To: 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.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
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:	
14-0088		3466	
Program:		Period Covered by Statement:	
Medicaid Hospital		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.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	Islet Acquisition							
34.	Ultra Sound							
35.	Allogeneic							
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics							
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:	14-0088	Medicaid Provider Number:	3466
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.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
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: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

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)	15,400,763	
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)	1,140,851	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	16,541,614	
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)	30,943,441	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	4,804,531	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	8,387,957	
	F. Coronary Care Unit	484,443	
	G. Burn ICU		
	H. Nursery Special Care		
	I. Nursery ICU	30,319,464	
	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)	74,939,836	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		58,398,222
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: 14-0088	Medicaid Provider Number: 3466
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)	16,541,614	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	16,541,614	
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)	16,541,614	

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:	14-0088	Medicaid Provider Number:	3466
Program:	Medicaid Hospital	Period Covered by Statement:	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)	58,398,222
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: 14-0088	Medicaid Provider Number: 3466
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

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:		Medicaid Provider Number:	
14-0088		3466	
Program:		Period Covered by Statement:	
Medicaid Hospital		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	17,993,869	699,617,364	0.025720	4,003,682		102,975	
2.	Recovery Room							
3.	Delivery and Labor Room	2,415,035	56,933,285	0.042419	50,637		2,148	
4.	Anesthesiology	8,988,340	310,949,787	0.028906	1,025,436		29,641	
5.	Radiology - Diagnostic	4,546,453	318,191,755	0.014288	1,565,298		22,365	
6.	Radiology - Therapeutic	5,138,035	227,493,462	0.022585	35,324		798	
7.	Nuclear Medicine							
8.	Laboratory	3,212,884	#####	0.002433	6,572,853		15,992	
9.	Blood							
10.	Blood - Administration	1,151,654	163,408,552	0.007048	966,290		6,810	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	3,284,504	274,464,487	0.011967	1,626,837		19,468	
17.	EEG	3,976,356	35,478,857	0.112077	391,933		43,927	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,029,899	48,146,066	0.021391	104,014		2,225	
21.	Ambulance							
22.	CT Scan	406,803	535,486,236	0.000760	610,740		464	
23.	MRI							
24.	Cardiac Cath							
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	Islet Acquisition							
34.	Ultra Sound							
35.	Allogeneic							
36.								
37.								
38.	Other							
39.	Other							
40.	Other							
41.	All Other Clinics							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	10,559,688	603,805,081	0.017489	861,920		15,074	
44.	Emergency	6,379,931	390,067,531	0.016356	1,578,822		25,823	
45.	Observation							
46.	Ancillary Total						287,710	

* 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:	14-0088	Medicaid Provider Number:	3466
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	2,445,006	21,666	112.85	1,048		118,267	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	790,703	4,711	167.84	878		147,364	
52.	Coronary Care Unit	305,818	1,162	263.18	76		20,002	
53.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU	3,093,994	15,058	205.47	2,762		567,508	
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)						853,141	
68.	Ancillary Total (from line 46)						287,710	
69.	Total (Lines 67-68)						1,140,851	

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2020 To: 06/30/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	4,764		4,764
Newborn Days			
Total Inpatient Revenue	74,939,836		74,939,836
Ancillary Revenue	30,943,441		30,943,441
Routine Revenue	43,996,395		43,996,395
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]