

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: 07/01/2020		To: 06/30/2021	

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 07/01/2020 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:		Medicaid Provider Number:	
14-0150		3098	
Program:		Period Covered by Statement:	
Medicaid-Hospital		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	307	112,055		68,416	61.06%		17,637	5.52
2.	Psych	50	18,250		12,558	68.81%		899	13.97
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,330		14,339	93.54%			
6.	Coronary Care Unit	19	6,935		6,349	91.55%			
7.	Pediatric ICU	14	5,110		555	10.86%			
8.	Neonatal ICU	52	18,980		7,696	40.55%			
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				2,584				
22.	Total	484	176,660		112,497	63.68%		18,536	5.93
23.	Observation Bed Days				5,822				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				197			12	16.42
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				197	0.18%		12	16.42

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service	10,189	559,741

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: 07/01/2020	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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	65,426,786	213,229,009	0.306838				
2.	Recovery Room	12,516,770	19,744,561	0.633935				
3.	Delivery and Labor Room	27,041,892	39,873,791	0.678187				
4.	Anesthesiology	8,157,188	95,357,570	0.085543				
5.	Radiology - Diagnostic	18,767,298	42,010,087	0.446733	1,143		511	
6.	Radiology - Therapeutic	9,954,712	25,007,829	0.398064				
7.	Nuclear Medicine	1,935,724	7,166,460	0.270109				
8.	Laboratory	52,896,937	455,725,668	0.116072	69,148		8,026	
9.	Blood							
10.	Blood - Administration	7,365,363	49,235,164	0.149596				
11.	Intravenous Therapy	957,332	2,568,509	0.372719	533		199	
12.	Respiratory Therapy	11,257,001	61,104,876	0.184224	956		176	
13.	Physical Therapy	16,739,151	24,453,974	0.684517	638		437	
14.	Occupational Therapy	7,095,695	10,511,589	0.675035	29,444		19,876	
15.	Speech Pathology	2,087,775	3,501,352	0.596277				
16.	EKG	745,271	7,345,331	0.101462	3,855		391	
17.	EEG	2,452,989	5,324,327	0.460713	1,292		595	
18.	Med. / Surg. Supplies	115,602,792	180,760,599	0.639535				
19.	Drugs Charged to Patients	119,688,237	349,722,090	0.342238	22,149		7,580	
20.	Renal Dialysis	12,831,419	37,529,610	0.341901				
21.	Ambulance							
22.	Ultrasound	3,686,033	18,051,788	0.204192				
23.	Radiology Angiography	7,631,353	66,964,588	0.113961				
24.	Radiology W. Harrison	2,650,401	13,962,339	0.189825				
25.	CT Scan	7,738,242	128,512,027	0.060214	8,457		509	
26.	MRI	6,971,741	78,629,533	0.088666	12,768		1,132	
27.	Cardiac Catheterization	3,097,361	30,430,622	0.101784				
28.	Lab Tissue Typing	2,759,249	8,810,498	0.313177				
29.	Lab Outreach	13,357,594	150,318,310	0.088862				
30.	Gastroenterology	9,144,544	35,389,590	0.258396				
31.	Bone Marrow Transplant	2,829,629	1,847,238	1.531816				
32.	Cardiac Services	8,810,648	29,575,870	0.297900				
33.	Kidney Acquisition	17,998,495	26,940,331	0.668087				
34.	Liver Acquisition	4,976,528	8,137,524	0.611553				
35.	Pancreas Acquisition	2,289,927	3,775,716	0.606488				
36.	Other Organ Acquisition	67,957	106,594	0.637531				
37.	Radio Mile Square	1,689,895	4,603,603	0.367081				
38.	Telemedicine Prgm	3,031,206	1,634,438	1.854586				
39.	Sleep Lab West Harr	2,127,145	4,081,409	0.521179				
40.	Sickle Cell Clinic	2,911,620	1,784,439	1.631672				
41.	Heart Ctr	182,724	439,046	0.416184				
42.	Hyperbarid Oxygen Ther.	196,640	227,096	0.865889				
Outpatient Service Cost Centers								
43.	Clinic	126,729,905	169,659,371	0.746967	18,642		13,925	
44.	Emergency	33,653,381	100,616,270	0.334473	2,707		905	
45.	Observation	14,685,646	22,925,751	0.640574				
46.	Total				171,732		54,262	

* 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: 07/01/2020 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)	187,260,737	30,058,003		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	74,238	12,558		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,522.44	2,393.53		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		197		
3.	Program general inpatient routine cost (Line 1c X Line 2)		471,525		
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)		471,525		

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	49,827,309	14,339	3,474.95		
9.	Coronary Care Unit	28,473,910	6,349	4,484.79		
10.	Pediatric ICU	7,285,833	555	13,127.63		
11.	Neonatal ICU	28,194,992	7,696	3,663.59		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	3,352,602	2,584	1,297.45		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					54,262
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					525,787

**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: 07/01/2020 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.	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:	14-0150	Medicaid Provider Number:	3098
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.	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: 07/01/2020 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.	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: 07/01/2020 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)	525,787	
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)	28,581	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	554,368	
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)	171,732	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	509,177	
	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)	680,909	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		126,541
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: 07/01/2020 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)	554,368	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	554,368	
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)	554,368	

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: 07/01/2020 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)	126,541
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: 07/01/2020 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:	14-0150	Medicaid Provider Number:	3098
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	13,084,875	213,229,009	0.061365				
2.	Recovery Room	183,190	19,744,561	0.009278				
3.	Delivery and Labor Room	1,896,562	39,873,791	0.047564				
4.	Anesthesiology	3,337,600	95,357,570	0.035001				
5.	Radiology - Diagnostic	389,770	42,010,087	0.009278	1,143		11	
6.	Radiology - Therapeutic	3,371,013	25,007,829	0.134798				
7.	Nuclear Medicine	409,549	7,166,460	0.057148				
8.	Laboratory	14,510,924	455,725,668	0.031841	69,148		2,202	
9.	Blood							
10.	Blood - Administration	2,532,311	49,235,164	0.051433				
11.	Intravenous Therapy	23,831	2,568,509	0.009278	533		5	
12.	Respiratory Therapy	2,813,968	61,104,876	0.046051	956		44	
13.	Physical Therapy	698,591	24,453,974	0.028568	638		18	
14.	Occupational Therapy	346,244	10,511,589	0.032939	29,444		970	
15.	Speech Pathology	272,627	3,501,352	0.077863				
16.	EKG	771,421	7,345,331	0.105022	3,855		405	
17.	EEG	49,399	5,324,327	0.009278	1,292		12	
18.	Med. / Surg. Supplies	4,653,134	180,760,599	0.025742				
19.	Drugs Charged to Patients	16,838,436	349,722,090	0.048148	22,149		1,066	
20.	Renal Dialysis	1,797,624	37,529,610	0.047899				
21.	Ambulance							
22.	Ultrasound	484,814	18,051,788	0.026857				
23.	Radiology Angiography	3,168,510	66,964,588	0.047316				
24.	Radiology W. Harrison	129,543	13,962,339	0.009278				
25.	CT Scan	2,676,065	128,512,027	0.020823	8,457		176	
26.	MRI	2,178,949	78,629,533	0.027712	12,768		354	
27.	Cardiac Catheterization	3,404,172	30,430,622	0.111867				
28.	Lab Tissue Typing	81,744	8,810,498	0.009278				
29.	Lab Outreach	1,394,653	150,318,310	0.009278				
30.	Gastroenterology	328,345	35,389,590	0.009278				
31.	Bone Marrow Transplant	17,139	1,847,238	0.009278				
32.	Cardiac Services	274,405	29,575,870	0.009278				
33.	Kidney Acquisition	661,623	26,940,331	0.024559				
34.	Liver Acquisition	452,865	8,137,524	0.055651				
35.	Pancreas Acquisition	35,031	3,775,716	0.009278				
36.	Other Organ Acquisition	86,754	106,594	0.813873				
37.	Radio Mile Square	42,712	4,603,603	0.009278				
38.	Telemedicine Prgm	15,164	1,634,438	0.009278				
39.	Sleep Lab West Harr	37,867	4,081,409	0.009278				
40.	Sickle Cell Clinic	16,556	1,784,439	0.009278				
41.	Heart Ctr	4,073	439,046	0.009277				
42.	Hyperbaric Oxygen Ther.	2,107	227,096	0.009278				
	Outpatient Ancillary Centers							
43.	Clinic	5,990,985	169,659,371	0.035312	18,642		658	
44.	Emergency	3,429,272	100,616,270	0.034083	2,707		92	
45.	Observation							
46.	Ancillary Total						6,013	

* 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: 07/01/2020 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	10,349,454	74,238	139.41				
48.	Psych	1,438,656	12,558	114.56	197		22,568	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,032,592	14,339	141.75				
52.	Coronary Care Unit	1,521,846	6,349	239.70				
53.	Pediatric ICU	760,208	555	1,369.74				
54.	Neonatal ICU	2,852,177	7,696	370.61				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	219,385	2,584	84.90				
67.	Routine Total (lines 47-66)						22,568	
68.	Ancillary Total (from line 46)						6,013	
69.	Total (Lines 67-68)						28,581	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0150	Medicaid Provider Number: 3098
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	916	(719)	197
Newborn Days			
Total Inpatient Revenue	4,014,630	(3,333,721)	680,909
Ancillary Revenue	1,053,702	(881,970)	171,732
Routine Revenue	2,960,928	(2,451,751)	509,177
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service		10,189	10,189
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2, Part I-Hospital - Removed L&D days and beds
 BHF Page 2 - Part II - Program days changed to agree with the IPCR
 BHF Page 2 - Part II - Program discharges adjusted to agree with the XIX length of stay as follows:
 197 Psych days / 16.36 XIX length of stay per Medicare report = 12 program discharges
 BHF Page 2 - Changed the total program O/P statistics to agree with the OPCR
 BHF Page 3 - Adjusted the I/P charges based upon the IPCR
 BHF Page 3 - Reclassified Blood to Blood Admin
 BHF Page 3 - Clinic costs and charges include Medicare lines 90, 93.01, 93.02, 93.03, 93.04, 93.05 and 76.08.
 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
 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
 BHF Page 3 - Behavioral Health on the IPCR is reported on the Clinic line of the cost report
 BHF Page 3 - Other therapeutic services on the IPCR are reported on the PT line of the cost report
 BHF Page 4 - Adjusted routine costs to agree with W/S C, Part I, col 1 of the Medicare report
 BHF Page 7 - Adjusted the routine charges to agree with IPCR
 BHF Supplemental 2a & 2b - GME costs included from W/S B, Part I, Col 25; \$99,465 of stepdown costs
 in Renal Dialysis not included