

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
☐ Corporation XXXX XXXX	☐ Partnership	☐ City	☐ Hospital District
☐ Other (Specify)	☐ Corporation	☐ County	☐ Other (Specify)

Type of Hospital

☐ General Short-Term XXXX XXXX	☐ 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)) Northwestern Memorial Hospital 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	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

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								
2.	Psych				405			147	2.76
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Special Care Nursery								
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								
22.	Total				405	0.13%		147	2.76

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				
2.	Recovery Room	15,439,879	78,162,028	0.197537	12,731		2,515	
3.	Delivery and Labor Room	42,327,653	231,650,379	0.182722				
4.	Anesthesiology	11,552,277	224,840,789	0.051380	5,177		266	
5.	Radiology - Diagnostic	61,452,495	491,165,064	0.125116	3,505		439	
6.	Radiology - Therapeutic	24,353,709	224,346,596	0.108554				
7.	Nuclear Medicine	24,639,089	107,016,805	0.230236				
8.	Laboratory	136,648,442	#####	0.101679	80,402		8,175	
9.	Blood							
10.	Blood - Administration	38,200,093	122,982,354	0.310614				
11.	Intravenous Therapy							
12.	Respiratory Therapy	23,810,354	117,116,668	0.203305	35,604		7,238	
13.	Physical Therapy	7,567,340	25,918,855	0.291963	583		170	
14.	Occupational Therapy	4,611,788	14,880,708	0.309917	81,515		25,263	
15.	Speech Pathology							
16.	EKG							
17.	EEG	9,048,152	68,385,355	0.132311	4,186		554	
18.	Med. / Surg. Supplies	84,679,760	368,604,195	0.229731	1,217		280	
19.	Drugs Charged to Patients	186,331,094	539,479,830	0.345390	29,317		10,126	
20.	Renal Dialysis	7,274,039	35,080,879	0.207351				
21.	Ambulance							
22.	Cardiac Cath Lab	6,102,755	122,597,631	0.049779				
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	24,152		1,691	
26.	Vascular Lab	2,323,331	45,148,301	0.051460				
27.	EPS							
28.	CT Scan	17,556,854	485,937,970	0.036130	29,759		1,075	
29.	GI Lab	21,050,450	200,612,045	0.104931				
30.	Transplant Clinic	7,315,011	6,270,239	1.166624				
31.	Transplant Acq (Liver/Kidney/Heart/Pan)	43,993,122	63,872,960	0.688760				
32.	Psych Clinic	4,676,014	844,056	5.539933	13,879		76,889	
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				
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				
44.	Emergency	39,557,175	324,281,887	0.121984	49,660		6,058	
45.	Observation - Distinct							
46.	Total				371,687		140,739	

* 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)		405		
3.	Program general inpatient routine cost (Line 1c X Line 2)		501,115		
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)		501,115		

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		
9.	Coronary Care Unit					
10.	Special Care Nursery	31,820,822	19,044	1,670.91		
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		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					140,739
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					641,854

**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 (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (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/Pancreas)							
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)	641,854	
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)	105,146	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	747,000	
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)	371,687	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	1,054,132	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Special Care Nursery		
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	1,425,819	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		678,819
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)	747,000	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	747,000	
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)	747,000	

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)	678,819
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)	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				
2.	Recovery Room	843,041	78,162,028	0.010786	12,731		137	
3.	Delivery and Labor Room	3,003,848	231,650,379	0.012967				
4.	Anesthesiology	122,773	224,840,789	0.000546	5,177		3	
5.	Radiology - Diagnostic	5,516,603	491,165,064	0.011232	3,505		39	
6.	Radiology - Therapeutic	1,759,747	224,346,596	0.007844				
7.	Nuclear Medicine	237,362	107,016,805	0.002218				
8.	Laboratory	4,493,494	#####	0.003344	80,402		269	
9.	Blood							
10.	Blood - Administration	343,765	122,982,354	0.002795				
11.	Intravenous Therapy							
12.	Respiratory Therapy	237,362	117,116,668	0.002027	35,604		72	
13.	Physical Therapy	16,370	25,918,855	0.000632	583			
14.	Occupational Therapy	24,555	14,880,708	0.001650	81,515		134	
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	196,437	368,604,195	0.000533	1,217		1	
19.	Drugs Charged to Patients	8,185	539,479,830	0.000015	29,317			
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	474,722	122,597,631	0.003872				
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				
30.	Transplant Clinic	409,243	6,270,239	0.065268				
31.	Transplant Acq (Liver/Kidney/Heart/Pa							
32.	Psych Clinic	409,243	844,056	0.484853	13,879		6,729	
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				
44.	Emergency	2,504,570	324,281,887	0.007723	49,660		384	
45.	Observation - Distinct							
46.	Ancillary Total						7,768	

* 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				
48.	Psych	2,218,100	9,225	240.44	405		97,378	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	8,012,989	37,004	216.54				
52.	Coronary Care Unit							
53.	Special Care Nursery	441,983	19,044	23.21				
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)						97,378	
68.	Ancillary Total (from line 46)						7,768	
69.	Total (Lines 67-68)						105,146	

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

	Provider's Records	Adjustments	Audited Cost Report
Inpatient Reconciliation			
Adult Days	405		405
Newborn Days			
Total Inpatient Revenue	1,425,819		1,425,819
Ancillary Revenue	371,687		371,687
Routine Revenue	1,054,132		1,054,132
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Part II - Program days agree with the IPCR; Discharge number agrees with W/S S-3 of Medicare report

BHF Page 3 - Blood storing and Blood are combined on the Blood Admin line

BHF Page 3 -Included Observation Beds (non-distinct) on line 35 of the cost report

BHF Page 3 - OR I/P Charges contain \$512,400 of other charge per the IPCR

BHF Page 3 - Added the Speech Therapy I/P Charges to the PT I/P charges as no cost to charge ratio for ST

BHF Page 3 - RT I/P Charges contain \$2,124,300 of EKG charges per the IPCR

BHF Page 3 - Clinic I/P Charges contain \$12,600 of Behavioral Health charges per the IPCR; reclassified to Psych Clinic

BHF Page 3 - I/P Charges agree with the IPCR.

BHF Page 3 - Reclassified the Clinic I/P Charge to Psych Clinic as this is Behavioral Health per the IPCR

BHF Page 7 - Routine charges on line 10B agree with the IPCR