

Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information Preliminary

Name of Hospital: NorthShore University HealthSystem		Medicare Provider Number: 14-0010	
Street: 2650 Ridge Avenue		Medicaid Provider Number: 5011	
City: Evanston	State: Illinois	Zip: 60201	
Period Covered by Statement:	From: 10/01/2017	To: 09/30/2018	

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> XXXX XXXX Other (Specify) Community	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/>

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)) NorthShore University Health 5011 for the cost report beginning 10/01/2017 and ending 09/30/2018 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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	583	212,795		132,020	62.04%		39,381	4.07
2.	Psych	33	12,045		9,262	76.89%		1,618	5.72
3.	Rehab	20	7,300		5,223	71.55%		403	12.96
4.	Other (Sub)								
5.	Intensive Care Unit	71	25,915		17,401	67.15%			
6.	Coronary Care Unit								
7.	ISCU	44	16,060		10,918	67.98%			
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	38	13,870		10,092	72.76%			
22.	Total	789	287,985		184,916	64.21%		41,402	4.22
23.	Observation Bed Days				24,195				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,149			1,240	6.82
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				716				
6.	Coronary Care Unit								
7.	ISCU				3,597				
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				1,498				
22.	Total				9,960	5.39%		1,240	6.82

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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	54,565,923	415,011,453	0.131481	2,986,205		392,629	
2.	Recovery Room	9,375,447	90,738,522	0.103324	539,944		55,789	
3.	Delivery and Labor Room	15,813,511	56,296,532	0.280897	2,085,173		585,719	
4.	Anesthesiology	8,997,564	73,523,427	0.122377	645,268		78,966	
5.	Radiology - Diagnostic	59,574,073	290,246,044	0.205254	1,869,345		383,691	
6.	Radiology - Therapeutic	9,799,662	90,593,280	0.108172	136,686		14,786	
7.	Nuclear Medicine	10,098,398	83,134,819	0.121470	178,284		21,656	
8.	Laboratory	68,253,290	444,733,386	0.153470	6,451,709		990,144	
9.	Blood							
10.	Blood - Administration	3,114,239	11,262,457	0.276515	293,873		81,260	
11.	Intravenous Therapy	4,080,153	12,044,574	0.338754	440,514		149,226	
12.	Respiratory Therapy	12,819,557	60,493,303	0.211917	3,306,833		700,774	
13.	Physical Therapy	41,722,652	104,380,560	0.399717	357,178		142,770	
14.	Occupational Therapy	4,533,587	13,364,452	0.339227	262,535		89,059	
15.	Speech Pathology	1,820,290	5,900,158	0.308515	125,834		38,822	
16.	EKG	11,073,661	175,593,431	0.063064	1,703,974		107,459	
17.	EEG	3,576,323	13,987,303	0.255684	193,057		49,362	
18.	Med. / Surg. Supplies	59,066,108	157,196,660	0.375747	1,576,717		592,447	
19.	Drugs Charged to Patients	165,818,203	566,594,389	0.292658	5,353,976		1,566,884	
20.	Renal Dialysis	3,709,626	6,648,708	0.557947	245,046		136,723	
21.	Ambulance							
22.	CT Scan	8,888,386	284,415,014	0.031251	2,622,720		81,963	
23.	MRI	11,039,603	189,292,584	0.058320	775,793		45,244	
24.	Cardiac Cath	7,991,478	82,535,723	0.096824	1,696,523		164,264	
25.	Vascular Lab	3,099,973	31,641,517	0.097972	287,673		28,184	
26.	Implant Devices Chgd.	88,184,539	249,586,397	0.353323	1,505,140		531,801	
27.	Cardiac Rehab	1,284,988	2,740,280	0.468926				
28.	ASC	17,406,256	24,282,054	0.716836	314		225	
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	178,066,695	304,108,009	0.585538	330,998		193,812	
44.	Emergency	35,495,728	304,276,165	0.116656	3,698,361		431,436	
45.	Observation	25,563,711	70,901,746	0.360551	803,178		289,587	
46.	Total				40,472,851		7,944,682	

* 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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	164,958,760	9,746,240	4,419,968	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	156,215	9,262	5,223	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,055.97	1,052.28	846.25	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,149			
3.	Program general inpatient routine cost (Line 1c X Line 2)	4,381,220			
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)	4,381,220			

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	36,369,702	17,401	2,090.09	716	1,496,504
9.	Coronary Care Unit					
10.	ISCU	13,428,310	10,918	1,229.92	3,597	4,424,022
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	3,274,480	10,092	324.46	1,498	486,041
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					7,944,682
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					18,732,469

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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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.	ISCU						
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)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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.	Vascular Lab							
26.	Implant Devices Chgd.							
27.	Cardiac Rehab							
28.	ASC							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic	131,072	304,108,009	0.000431	330,998		143	
44.	Emergency	1,499,998	304,276,165	0.004930	3,698,361		18,233	
45.	Observation							
46.	Ancillary Total						18,376	

* 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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	20,218,140	156,215	129.43	4,149		537,005	
48.	Psych	9,006	9,262	0.97				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,269,250	17,401	72.94	716		52,225	
52.	Coronary Care Unit							
53.	ISCU							
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)						589,230	
68.	Ancillary Total (from line 46)						18,376	
69.	Total (Lines 67-68)						607,606	

**Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges**

Preliminary

Medicare Provider Number: 14-0010		Medicaid Provider Number: 5011	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2017 To: 09/30/2018	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	18,732,469	
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)	607,606	
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)	1,037,269	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	20,377,344	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	40,472,851	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	9,341,154	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	3,924,633	
	F. Coronary Care Unit		
	G. ISCU	17,909,318	
	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	1,929,309	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	73,577,265	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		53,199,921
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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	20,377,344	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	20,377,344	
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)	20,377,344	

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

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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)	53,199,921
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

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

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

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

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	7,835,364	415,011,453	0.018880	2,986,205		56,380	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	3,333,370	73,523,427	0.045338	645,268		29,255	
5.	Radiology - Diagnostic	1,771,157	290,246,044	0.006102	1,869,345		11,407	
6.	Radiology - Therapeutic	454,330	90,593,280	0.005015	136,686		685	
7.	Nuclear Medicine							
8.	Laboratory	2,813,442	444,733,386	0.006326	6,451,709		40,814	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,260,947	175,593,431	0.007181	1,703,974		12,236	
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.	Vascular Lab							
26.	Implant Devices Chgd.							
27.	Cardiac Rehab							
28.	ASC							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	485,914	304,108,009	0.001598	330,998		529	
44.	Emergency	3,289,638	304,276,165	0.010811	3,698,361		39,983	
45.	Observation							
46.	Ancillary Total						191,289	

* 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: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

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	28,838,997	156,215	184.61	4,149		765,947	
48.	Psych	1,069,011	9,262	115.42				
49.	Rehab	228,380	5,223	43.73				
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	ISCU	242,957	10,918	22.25	3,597		80,033	
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)						845,980	
68.	Ancillary Total (from line 46)						191,289	
69.	Total (Lines 67-68)						1,037,269	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-0010	Medicaid Provider Number: 5011
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2017 To: 09/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,462		8,462
Newborn Days	1,498		1,498
Total Inpatient Revenue	73,577,264	1	73,577,265
Ancillary Revenue	40,472,850	1	40,472,851
Routine Revenue	33,104,414		33,104,414
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs/total charges agree with as filed W/S C

GME costs were adjusted to agree with as filed W/S B Part 1, column 25

BHF Page 3 - Blood was reclassified to Blood Administration

Adjustment due to rounding