

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: Advocate Lutheran General Hospital(Childrens)		Medicare Provider Number: 14-0223
Street: 1775 W. Dempster Street		Medicaid Provider Number: 16016
City: Park Ridge	State: Illinois	Zip: 60068
Period Covered by Statement:	From: 01/01/2020	To: 12/31/2020

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☒ Church	☐ Individual	☐ State
☐ Corporation	☐ Partnership	☐ City
☐ Other (Specify)	☐ Corporation	☐ County

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☒ Other (Specify) Children's

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)) Advocate Lutheran General H 16016 for the cost report beginning 01/01/2020 and ending 12/31/2020 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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	48	17,568		11,792	67.12%		3,329	7.31
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	19	6,954		1,475	21.21%			
6.	Coronary Care Unit								
7.	Neonatal Care Unit	54	19,764		11,059	55.96%			
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	10	3,660		135	3.69%			
22.	Total	131	47,946		24,461	51.02%		3,329	7.31
23.	Observation Bed Days								

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,001			253	8.60
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				238				
6.	Coronary Care Unit								
7.	Neonatal Care Unit				936				
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				8				
22.	Total				2,183	8.92%		253	8.60

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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	31,161,596	129,433,179	0.240754	401,375		96,633	
2.	Recovery Room	3,804,000	16,962,302	0.224262	37,430		8,394	
3.	Delivery and Labor Room	10,976,635	31,695,066	0.346320	7,177		2,486	
4.	Anesthesiology	2,624,845	54,460,941	0.048197	180,188		8,685	
5.	Radiology - Diagnostic	23,419,384	142,738,051	0.164072	629,085		103,215	
6.	Radiology - Therapeutic	9,738,181	52,849,933	0.184261				
7.	Nuclear Medicine	5,402,794	26,861,195	0.201138	47,985		9,652	
8.	Laboratory	26,641,804	208,706,455	0.127652	995,416		127,067	
9.	Blood							
10.	Blood - Administration	5,074,008	5,032,491	1.008250	185,167		186,695	
11.	Intravenous Therapy							
12.	Respiratory Therapy	15,648,132	50,173,400	0.311881	1,949,757		608,092	
13.	Physical Therapy	21,061,339	57,130,744	0.368652	188,063		69,330	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	7,273,316	43,258,259	0.168137	143,799		24,178	
17.	EEG	3,527,983	16,882,015	0.208979	124,188		25,953	
18.	Med. / Surg. Supplies	76,550,012	66,508,931	1.150973	439,276		505,595	
19.	Drugs Charged to Patients	62,004,182	353,299,337	0.175500	2,907,868		510,331	
20.	Renal Dialysis	2,208,242	6,049,430	0.365033	11,445		4,178	
21.	Ambulance							
22.	CT Scan	6,974,715	141,939,068	0.049139	183,148		9,000	
23.	MRI	4,636,829	60,355,942	0.076825	245,502		18,861	
24.	Cardiac Cath	8,013,959	53,250,147	0.150496				
25.	Implants Charged	42,090,656	89,070,924	0.472552	312,340		147,597	
26.	ASC	6,509,578	37,708,248	0.172630	95,852		16,547	
27.	Rehab Medicine	1,937,901	3,119,671	0.621188	4,182		2,598	
28.	Day Hospital	2,003,492	2,763,897	0.724879				
29.	Lithotripter	739,894	1,834,358	0.403353				
30.	GI Lab	6,341,771	44,478,769	0.142580	4,635		661	
31.	Cardiac Rehab	1,143,473	1,999,191	0.571968				
32.	Diabetes Care Center	342,814	55,183	6.212312				
33.	Outpatient Center	6,697,623	18,683,062	0.358486	8,690		3,115	
34.	Pain Clinic	944,612	3,863,886	0.244472				
35.	Anti Coag Lab	951,105	1,488,683	0.638890				
36.	Heart Risk Assessment		1,799,422					
37.	Allogeneic Stem Cell Acq	1,116,712	1,120,000	0.997064				
38.	Car-T Cells	1,368,852	29,328,929	0.046672				
39.	Crystal Lake Infusion	9,199,005						
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	28,173,065	125,639,369	0.224238	309,725		69,452	
45.	Observation	13,256,982	36,655,281	0.361666	59,098		21,374	
46.	Total				9,471,391		2,579,689	

* 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: 14-0223	Medicaid Provider Number: 16016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	14,163,788			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	11,792			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,201.14			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,001			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,202,341			
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)	1,202,341			

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	3,611,119	1,475	2,448.22	238	582,676
9.	Coronary Care Unit					
10.	Neonatal Care Unit	17,350,988	11,059	1,568.95	936	1,468,537
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	54,063	135	400.47	8	3,204
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,579,689
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					5,836,447

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

Preliminary

Medicare Provider Number:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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.	Neonatal Care Unit						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
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:	
14-0223		16016	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2020	To: 12/31/2020

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.	Implants Charged							
26.	ASC							
27.	Rehab Medicine							
28.	Day Hospital							
29.	Lithotripter							
30.	GI Lab							
31.	Cardiac Rehab							
32.	Diabetes Care Center							
33.	Outpatient Center							
34.	Pain Clinic							
35.	Anti Coag Lab							
36.	Heart Risk Assessment							
37.	Allogeneic Stem Cell Acq							
38.	Car-T Cells							
39.	Crystal Lake Infusion							
40.	Other							
41.	Other							
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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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.	Neonatal Care Unit							
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

Preliminary

Medicare Provider Number: 14-0223	Medicaid Provider Number: 16016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	5,836,447	
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)	567,346	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	6,403,793	
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)	9,471,391	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,568,779	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,506,187	
	F. Coronary Care Unit		
	G. Neonatal Care Unit	6,310,487	
	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	28,315	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	20,885,159	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		14,481,366
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: 14-0223	Medicaid Provider Number: 16016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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)	6,403,793	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,403,793	
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)	6,403,793	

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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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)	14,481,366
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: 14-0223	Medicaid Provider Number: 16016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	4,661,306	129,433,179	0.036013	401,375		14,455	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	451,838	208,706,455	0.002165	995,416		2,155	
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.	Implants Charged							
26.	ASC							
27.	Rehab Medicine							
28.	Day Hospital							
29.	Lithotripter							
30.	GI Lab							
31.	Cardiac Rehab							
32.	Diabetes Care Center							
33.	Outpatient Center							
34.	Pain Clinic							
35.	Anti Coag Lab							
36.	Heart Risk Assessment							
37.	Allogeneic Stem Cell Acq							
38.	Car-T Cells							
39.	Crystal Lake Infusion							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	2,724,858	125,639,369	0.021688	309,725		6,717	
45.	Observation							
46.	Ancillary Total						23,327	

* 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:	14-0223	Medicaid Provider Number:	16016
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	2,888,544	11,792	244.96	1,001		245,205	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	375,464	1,475	254.55	238		60,583	
52.	Coronary Care Unit							
53.	Neonatal Care Unit	2,814,765	11,059	254.52	936		238,231	
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)						544,019	
68.	Ancillary Total (from line 46)						23,327	
69.	Total (Lines 67-68)						567,346	

Preliminary

Medicare Provider Number: 14-0223	Medicaid Provider Number: 16016
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,175		2,175
Newborn Days	8		8
Total Inpatient Revenue	20,885,160	(1)	20,885,159
Ancillary Revenue	9,471,392	(1)	9,471,391
Routine Revenue	11,413,768		11,413,768
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]