

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: Little Company of Mary Hospital	Medicare Provider Number: 14-0179	
Street: 2800 W. 95th Street	Medicaid Provider Number: 3072	
City: Evergreen Park	State: IL	Zip: 60642
Period Covered by Statement:	From: 07/01/2019	To: 01/31/2020

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)

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)) Little Company of Mary Hospi 3072 for the cost report beginning 07/01/2019 and ending 01/31/2020 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
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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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	184	39,560		27,871	70.45%		6,681	4.71
2.	Psych	24	5,160		1,227	23.78%		249	4.93
3.	Other								
4.	Other (Sub)								
5.	Intensive Care Unit	26	5,590		2,709	48.46%			
6.	Coronary Care Unit								
7.	NICU	10	2,150		867	40.33%			
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	24	5,160		1,039	20.14%			
22.	Total	268	57,620		33,713	58.51%		6,930	4.71
23.	Observation Bed Days				4,836				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,325			492	4.22
2.	Psych								
3.	Other								
4.	Other (Sub)								
5.	Intensive Care Unit				147				
6.	Coronary Care Unit								
7.	NICU				603				
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				216				
22.	Total				2,291	6.80%		492	4.22

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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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	8,995,321	28,866,256	0.311621	480,481		149,728	
2.	Recovery Room							
3.	Delivery and Labor Room	3,166,823	6,140,072	0.515763	506,691		261,332	
4.	Anesthesiology	559,748	10,668,805	0.052466	232,516		12,199	
5.	Radiology - Diagnostic	5,737,995	29,368,454	0.195380	403,632		78,862	
6.	Radiology - Therapeutic	3,399,986	9,900,242	0.343425				
7.	Nuclear Medicine	1,416,921	7,749,467	0.182841	131,744		24,088	
8.	Laboratory	9,315,214	94,714,093	0.098351	2,553,484		251,138	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	2,724,325	21,690,176	0.125602	695,097		87,306	
13.	Physical Therapy	2,114,065	6,737,210	0.313789	84,909		26,644	
14.	Occupational Therapy							
15.	Speech Pathology	326,099	1,536,529	0.212231	23,992		5,092	
16.	EKG	1,826,713	12,398,157	0.147337	295,278		43,505	
17.	EEG	239,553	1,183,811	0.202357	18,921		3,829	
18.	Med. / Surg. Supplies	6,214,028	14,228,360	0.436735	567,492		247,844	
19.	Drugs Charged to Patients	15,501,110	82,821,669	0.187162	1,825,627		341,688	
20.	Renal Dialysis	1,055,620	3,616,579	0.291884	84,212		24,580	
21.	Ambulance							
22.	Ultrasound	1,405,990	12,210,081	0.115150	214,473		24,697	
23.	CT Scan	1,701,038	59,695,621	0.028495	1,154,904		32,909	
24.	Cardiac Cath	1,719,948	13,620,226	0.126279	593,515		74,948	
25.	OS SVCS	19,456	17,363	1.120544	2,367		2,652	
26.	GI Lab	2,356,537	12,738,806	0.184989	111,670		20,658	
27.	MRI	874,740	7,788,184	0.112316	145,025		16,289	
28.	Outpatient Rehab	1,502,483	2,823,976	0.532045				
29.	Wound Care	850,498	2,220,772	0.382974				
30.	Sleep Lab	338,233	1,191,971	0.283759				
31.	Palos diagnostic CTR	182,578	391,164	0.466756				
32.	Implants	3,942,157	10,986,161	0.358829	144,901		51,995	
33.	Care Stations	1,944,043	3,636,544	0.534585				
34.	OP Care Ctr	2,530,865	12,209,325	0.207290				
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	783,124	997,477	0.785105	292		229	
44.	Emergency	8,200,965	62,623,400	0.130957	1,158,364		151,696	
45.	Observation	4,412,850	9,700,661	0.454902	60,593		27,564	
46.	Total				11,490,180		1,961,472	

* 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: 14-0179	Medicaid Provider Number: 3072
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 01/31/2020

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Other	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	29,845,111	1,795,783		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	32,707	1,227		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	912.50	1,463.56		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,325			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,209,063			
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)	1,209,063			

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	4,948,937	2,709	1,826.85	147	268,547
9.	Coronary Care Unit					
10.	NICU	1,925,509	867	2,220.89	603	1,339,197
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	901,133	1,039	867.31	216	187,339
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,961,472
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,965,618

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

Preliminary

Medicare Provider Number:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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.	Other						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	NICU						
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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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	398,980	28,866,256	0.013822	480,481		6,641	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	1,804,866	10,668,805	0.169172	232,516		39,335	
5.	Radiology - Diagnostic	34,548	29,368,454	0.001176	403,632		475	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	18,179	94,714,093	0.000192	2,553,484		490	
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.	CT Scan							
24.	Cardiac Cath							
25.	OS SVCS							
26.	GI Lab							
27.	MRI							
28.	Outpatient Rehab							
29.	Wound Care							
30.	Sleep Lab							
31.	Palos diagnostic CTR							
32.	Implants							
33.	Care Stations	397,697	3,636,544	0.109361				
34.	OP Care Ctr							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	484,167	62,623,400	0.007731	1,158,364		8,955	
45.	Observation							
46.	Ancillary Total						55,896	

* 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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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	543,197	32,707	16.61	1,325		22,008	
48.	Psych							
49.	Other							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU	998,716	867	1,151.92	603		694,608	
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)						716,616	
68.	Ancillary Total (from line 46)						55,896	
69.	Total (Lines 67-68)						772,512	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0179	Medicaid Provider Number: 3072
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 01/31/2020

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)	4,965,618	
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)	772,512	
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)	5,631	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	5,743,761	
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)	11,490,180	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,145,777	
	B. Psych		
	C. Other		
	D. Other (Sub)		
	E. Intensive Care Unit	559,168	
	F. Coronary Care Unit		
	G. NICU	1,416,546	
	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	453,178	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	17,064,849	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		11,321,088
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: 14-0179	Medicaid Provider Number: 3072
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 01/31/2020

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)	5,743,761	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,743,761	
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)	5,743,761	

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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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)	11,321,088
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: 14-0179	Medicaid Provider Number: 3072
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 01/31/2020

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 Other	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 Other	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 Other	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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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							
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.	CT Scan							
24.	Cardiac Cath							
25.	OS SVCS							
26.	GI Lab							
27.	MRI							
28.	Outpatient Rehab							
29.	Wound Care							
30.	Sleep Lab							
31.	Palos diagnostic CTR							
32.	Implants							
33.	Care Stations							
34.	OP Care Ctr							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary 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 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:	14-0179	Medicaid Provider Number:	3072
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 01/31/2020

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	138,923	32,707	4.25	1,325		5,631	
48.	Psych							
49.	Other							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	NICU							
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)						5,631	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						5,631	

Preliminary

Medicare Provider Number: 14-0179	Medicaid Provider Number: 3072
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 01/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	2,075		2,075
Newborn Days	216		216
Total Inpatient Revenue	17,064,850	(1)	17,064,849
Ancillary Revenue	11,490,181	(1)	11,490,180
Routine Revenue	5,574,669		5,574,669
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

[illegible]