

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: Ingalls Hospital	Medicare Provider Number: 14-0191	
Street: One Ingalls Drive	Medicaid Provider Number: 8006	
City: Harvey	State: Illinois	Zip: 60426
Period Covered by Statement:	From: 07/01/2019	To: 06/30/2020

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ XXXX Corporation	☐ Partnership	☐ City	☐ Hospital District
☐ XXXX Other (Specify)	☐ Corporation	☐ County	☐ Other (Specify)

Type of Hospital

☐ XXXX General Short-Term	☐ Psychiatric	☐ Cancer
☐ XXXX 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	☐
☐ XXXX 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)) Ingalls Hospital 8006 for the cost report beginning 07/01/2019 and ending 06/30/2020 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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	157	57,482		39,909	69.43%		9,394	4.71
2.	Psych	82	29,930		15,860	52.99%		2,357	6.73
3.	Rehab	42	15,372		8,200	53.34%		550	14.91
4.	Other (Sub)								
5.	Intensive Care Unit	25	9,150		4,364	47.69%			
6.	Coronary Care Unit								
7.	Other								
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				2,053				
22.	Total	306	111,934		70,386	62.88%		12,301	5.56
23.	Observation Bed Days				4,554				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				1,901			302	6.29
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Other								
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				1,901	2.70%		302	6.29

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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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	17,497,541	91,075,883	0.192120				
2.	Recovery Room	1,649,730	13,301,176	0.124029				
3.	Delivery and Labor Room	1,386,879	3,140,504	0.441610				
4.	Anesthesiology	672,003	18,206,208	0.036911				
5.	Radiology - Diagnostic	10,531,388	34,488,833	0.305356	612		187	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,671,815	7,608,477	0.219731				
8.	Laboratory	17,648,158	179,716,783	0.098200	51,043		5,012	
9.	Blood							
10.	Blood - Administration	1,907,660	9,491,552	0.200985				
11.	Intravenous Therapy							
12.	Respiratory Therapy	4,067,565	26,775,312	0.151915	13,911		2,113	
13.	Physical Therapy	3,827,787	16,865,718	0.226957				
14.	Occupational Therapy	2,206,760	8,018,379	0.275213				
15.	Speech Pathology	818,726	3,713,665	0.220463				
16.	EKG	2,985,505	23,587,601	0.126571	11,406		1,444	
17.	EEG	476,222	984,881	0.483533				
18.	Med. / Surg. Supplies	15,241,169	25,943,066	0.587485	561		330	
19.	Drugs Charged to Patients	36,309,913	172,862,738	0.210051	15,906		3,341	
20.	Renal Dialysis	1,441,324	6,188,516	0.232903				
21.	Ambulance							
22.	Ultrasound	2,476,274	17,195,134	0.144010				
23.	Special Procedures	4,246,584	22,176,364	0.191491				
24.	CT Scan	2,504,920	103,815,979	0.024128	7,281		176	
25.	MRI	1,395,424	16,799,549	0.083063	3			
26.	Cardiac Cath	3,527,543	18,089,058	0.195010				
27.	Pulmonary Function	116,543	685,589	0.169990				
28.	Sleep Lab	184,942	1,042,022	0.177484				
29.	Psych Services	2,421,565	6,075,420	0.398584				
30.	Infusion Therapy	767,517	4,532,618	0.169332				
31.	FCC Infusion Therapy	1,092,586	10,249,888	0.106595				
32.	Pharmacy Vaccine	56,296	740,902	0.075983				
33.	Cardiac Rehab	785,246	656,264	1.196540				
34.	Hyperbaric Oxy. Ther.	1,552,685	6,968,202	0.222824	450		100	
35.	Retinal Vascular	1,379,008	789,946	1.745699				
36.	Psych Ancillary	2,812,345	5,775,451	0.486948				
37.	Other							
38.	Other							
39.	IFCC Clinic	31,561,960	275,033,457	0.114757				
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic							
44.	Emergency	14,069,696	127,831,898	0.110064	6,883		758	
45.	Observation	5,128,953	15,523,667	0.330396				
46.	Total				108,056		13,461	

* 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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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)	47,460,773	15,484,360	12,238,572	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	44,463	15,860	8,200	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,067.42	976.32	1,492.51	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		1,901		
3.	Program general inpatient routine cost (Line 1c X Line 2)		1,855,984		
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)		1,855,984		

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	10,824,682	4,364	2,480.45		
9.	Coronary Care Unit					
10.	Other					
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	3,015,352	2,053	1,468.75		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					13,461
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,869,445

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

Preliminary

Medicare Provider Number:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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.	Other						
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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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.	Ultrasound							
23.	Special Procedures							
24.	CT Scan							
25.	MRI							
26.	Cardiac Cath							
27.	Pulmonary Function							
28.	Sleep Lab							
29.	Psych Services							
30.	Infusion Therapy							
31.	FCC Infusion Therapy							
32.	Pharmacy Vaccine							
33.	Cardiac Rehab							
34.	Hyperbaric Oxy. Ther.							
35.	Retinal Vascular							
36.	Psych Ancillary							
37.	Other							
38.	Other							
39.	IFCC Clinic							
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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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.	Other							
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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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)	1,869,445	
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,869,445	
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)	108,056	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	4,410,547	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	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)	4,518,603	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		2,649,158
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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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)	1,869,445	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,869,445	
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)	1,869,445	

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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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)	2,649,158
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: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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.	Special Procedures							
24.	CT Scan							
25.	MRI							
26.	Cardiac Cath							
27.	Pulmonary Function							
28.	Sleep Lab							
29.	Psych Services							
30.	Infusion Therapy							
31.	FCC Infusion Therapy							
32.	Pharmacy Vaccine							
33.	Cardiac Rehab							
34.	Hyperbaric Oxy. Ther.							
35.	Retinal Vascular							
36.	Psych Ancillary							
37.	Other							
38.	Other							
39.	IFCC Clinic							
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:	14-0191	Medicaid Provider Number:	8006
Program:	Medicaid Hospital	Period Covered by Statement:	From: 07/01/2019 To: 06/30/2020

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
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 Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-0191	Medicaid Provider Number: 8006
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2019 To: 06/30/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,901		1,901
Newborn Days			
Total Inpatient Revenue	4,518,603		4,518,603
Ancillary Revenue	108,056		108,056
Routine Revenue	4,410,547		4,410,547
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adjusted Routine days to match W/S S-3 with splits between Acute, Psych, and Children's facilities.

see attached worksheet

BHF Page 3 - Total costs were adjusted to agree with as filed W/S C Part 1, column 1.

BHF Page 3 - Reclassified Blood to Blood Administration

BHF Page 3 - Reclassified data filed on Hemodynamics line to Cardiac Cath

BHF Page 4 -Costs for Adults and Peds allocated to Acute, Psych, and Children's Hospital based upon days.

see attached worksheet

BHF Page 3 - Implant Devices included with Medical Supplies