

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: Northern Illinois Medical Center		Medicare Provider Number: 14-0116	
Street: 4201 Medical Center Drive		Medicaid Provider Number: 13020	
City: McHenry	State: Illinois	Zip: 60050	
Period Covered by Statement:	From: 09/01/2020	To: 08/31/2021	

Type of Control

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

Type of Hospital

☐ XXXX XXXX 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)

☐ XXXX XXXX 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)) Northern Illinois Medical Center 13020 for the cost report beginning 09/01/2020 and ending 08/31/2021 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

Name (Typewritten)
Title
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:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	196	71,540		55,057	76.96%		14,828	4.18
2.	Psych	34	12,410		9,551	76.96%		2,285	4.18
3.	Rehab	22	8,030		5,609	69.85%		373	15.04
4.	Other (Sub)								
5.	Intensive Care Unit	30	10,950		6,904	63.05%			
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				4,265				
22.	Total	282	102,930		81,386	79.07%		17,486	4.41
23.	Observation Bed Days				11,851				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,367			704	3.62
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				183				
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				554				
22.	Total				3,104	3.81%		704	3.62

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:		Medicaid Provider Number:	
14-0116		13020	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 09/01/2020	To: 08/31/2021

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	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	44,971,088	286,646,719	0.156887	1,311,811		205,806	
2.	Recovery Room	4,381,821	36,666,732	0.119504	133,200		15,918	
3.	Delivery and Labor Room	3,591,910	7,988,164	0.449654	239,344		107,622	
4.	Anesthesiology	267,441	111,066,737	0.002408	236,728		570	
5.	Radiology - Diagnostic	21,009,940	155,774,965	0.134874	498,748		67,268	
6.	Radiology - Therapeutic	5,284,006	59,101,288	0.089406	5,461		488	
7.	Nuclear Medicine	3,584,335	35,599,557	0.100685	48,694		4,903	
8.	Laboratory	20,197,472	175,965,359	0.114781	2,267,203		260,232	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,664,017	18,185,179	0.421443	255,579		107,712	
13.	Physical Therapy	21,478,186	81,555,159	0.263358	161,984		42,660	
14.	Occupational Therapy	3,551,425	12,459,912	0.285028	99,346		28,316	
15.	Speech Pathology	1,595,342	13,083,522	0.121935	93,773		11,434	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	36,209,518	59,429,914	0.609281	539,986		329,003	
19.	Drugs Charged to Patients	9,376,050	45,400,125	0.206520	1,744,679		360,311	
20.	Renal Dialysis	2,421,350	1,700,618	1.423806	54,949		78,237	
21.	Ambulance							
22.	CT Scan	6,087,126	252,580,023	0.024100	1,696,189		40,878	
23.	MRI	2,237,713	66,454,877	0.033673	311,589		10,492	
24.	Cardiac Cath	7,254,090	52,478,230	0.138230	390,113		53,925	
25.	Sleep Lab/Neurology	1,400,163	8,238,063	0.169963	4,884		830	
26.	Impl. Dev. Charged	33,835,415	65,816,444	0.514088				
27.	Injectable Drugs	62,050,532	204,209,949	0.303857				
28.	Wound Care	4,065,769	17,629,074	0.230629				
29.	Cardiac Rehab	1,397,737	5,850,597	0.238905				
30.	Diabetes Center	707,595	1,248,592	0.566714				
31.	Behavioral Health	3,174,456	8,170,922	0.388506				
32.	DME	2,240,064	7,565,486	0.296090				
33.	Cardiology	5,566,968	25,180,055	0.221086				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	7,809,059	8,098,552	0.964254	2,296		2,214	
44.	Emergency	30,381,151	261,071,154	0.116371	157,461		18,324	
45.	Observation	15,284,946	31,739,126	0.481581	646,152		311,175	
46.	Total				10,900,169		2,058,318	

* 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: 14-0116	Medicaid Provider Number: 13020
Program: Medicaid Hospital	Period Covered by Statement: From: 09/01/2020 To: 08/31/2021

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	86,295,358	12,318,511	8,424,262	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	66,908	9,551	5,609	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,289.76	1,289.76	1,501.92	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,367			
3.	Program general inpatient routine cost (Line 1c X Line 2)	3,052,862			
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)	3,052,862			

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	20,789,042	6,904	3,011.16	183	551,042
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	4,700,962	4,265	1,102.22	554	610,630
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,058,318
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					6,272,852

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

Preliminary -

Medicare Provider Number:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	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 (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

BHF Page 6(a)

Preliminary -

Medicare Provider Number:		Medicaid Provider Number:	
14-0116		13020	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 09/01/2020	To: 08/31/2021

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath							
25.	Sleep Lab/Neurology							
26.	Impl. Dev. Charged							
27.	Injectable Drugs							
28.	Wound Care							
29.	Cardiac Rehab							
30.	Diabetes Center							
31.	Behavioral Health							
32.	DME							
33.	Cardiology							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
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:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	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: 14-0116	Medicaid Provider Number: 13020
Program: Medicaid Hospital	Period Covered by Statement: From: 09/01/2020 To: 08/31/2021

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	6,272,852	
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)	146,716	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	6,419,568	
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)	10,900,169	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	3,945,129	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	305,010	
	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	923,363	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	16,073,671	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		9,654,103
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: 14-0116	Medicaid Provider Number: 13020
Program: Medicaid Hospital	Period Covered by Statement: From: 09/01/2020 To: 08/31/2021

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	6,419,568	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,419,568	
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)	6,419,568	

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:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	9,654,103
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: 14-0116	Medicaid Provider Number: 13020
Program: Medicaid Hospital	Period Covered by Statement: From: 09/01/2020 To: 08/31/2021

Part I - Apportionment of Cost for the Services of Teaching Physicians

Part A. Cost of Physicians Direct Medical and Surgical Services

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

Part B. Program Data

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

Part C. Program Cost

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary -

Medicare Provider Number:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	435,022	286,646,719	0.001518	1,311,811		1,991	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	124,193	111,066,737	0.001118	236,728		265	
5.	Radiology - Diagnostic	124,193	155,774,965	0.000797	498,748		398	
6.	Radiology - Therapeutic	92,971	59,101,288	0.001573	5,461		9	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	155,414	18,185,179	0.008546	255,579		2,184	
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.	Sleep Lab/Neurology							
26.	Impl. Dev. Charged							
27.	Injectable Drugs							
28.	Wound Care							
29.	Cardiac Rehab							
30.	Diabetes Center							
31.	Behavioral Health							
32.	DME							
33.	Cardiology	528,687	25,180,055	0.020996				
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	310,829	8,098,552	0.038381	2,296		88	
44.	Emergency	186,636	261,071,154	0.000715	157,461		113	
45.	Observation							
46.	Ancillary Total						5,048	

* 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:	14-0116	Medicaid Provider Number:	13020
Program:	Medicaid Hospital	Period Covered by Statement:	From: 09/01/2020 To: 08/31/2021

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics	3,375,731	66,908	50.45	2,367		119,415	
48.	Psych	481,880	9,551	50.45				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	839,516	6,904	121.60	183		22,253	
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)						141,668	
68.	Ancillary Total (from line 46)						5,048	
69.	Total (Lines 67-68)						146,716	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary -

Medicare Provider Number: 14-0116	Medicaid Provider Number: 13020
Program: Medicaid Hospital	Period Covered by Statement: From: 09/01/2020 To: 08/31/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	3,304	(754)	2,550
Newborn Days	554		554
Total Inpatient Revenue	18,139,152	(2,065,481)	16,073,671
Ancillary Revenue	11,275,600	(375,431)	10,900,169
Routine Revenue	6,863,552	(1,690,050)	5,173,502
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - The Hospital total bed days available on the as-filed cost report is based on a 365 day period not a 366 day period which is what's reported on W/S S-3 of the Medicare report. Thus these don't agree with W/S S-3.
BHF Page 2 - Added Observation Bed Days
BHF Page 2 - No Hospital Psych beds/days on the as-filed cost report or the Medicare report. There are 34 Psych beds per an email from the provider. There are 593 program Psych days per the IPCR. A Psych report was created by HFS based upon this information. See the attached spreadsheet.
BHF Page 2 - Reclassified 593 Psych days from A&P on the hospital report and reported the 593 days on the Psych report
BHF Page 3 - Removed the Psych I/P charges per the IPCR from the I/P charges on the hospital report and placed on the Psych report
BHF Page 3 - Removed the Psych IV Therapy charges on the IPCR from the I/P Labs charges and placed on the Psych report
BHF Page 3 - Removed the \$40,629 of I/P Behavioral Therapy charges and added to the Psych report; Total Behavioral Health charges on the IPCR are \$75,776. The remaining balance is adjusted out of I/P drug charges and added to the Psych report
BHF Page 3 - Reclassified \$483,419 of EKG I/P charges to CT Scan I/P charges as no costs/charges for EKG on the cost report
BHF Page 4 - Allocated the routine costs between A&P and Psych; see attached spreadsheet
BHF Page 7 - Adjusted out the Psych routine charges from the IPCR and added to the Psych cost report
\$6,863,552 Reported on the hospital report - 1,690,050 Psych routine charges = \$5,173,502 to allocate as follows:
A&P 2367 program days / 3104 total program days * \$5,173,502 = \$3,945,129 A&P routine charges
ICU 183 program days / 3104 total program days * \$5,173,502 = \$305,010
Nursery 554 program days / 3104 total program days * \$5,173,502 = \$923,363
BHF Supplemental 2a & 2b - Added the GME expenses from W/S B, Part I, Col 25 of the Medicare report