

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: Franciscan St. Margaret-Hammond		Medicare Provider Number: 15-0004	
Street: 5454 Hohman Avenue		Medicaid Provider Number: 8017	
City: Hammond	State: IN	Zip: 46320	
Period Covered by Statement:	From: 01/01/2021	To: 12/31/2021	

Type of Control

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

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)) Franciscan St. Margaret-Ham 8017 for the cost report beginning 01/01/2021 and ending 12/31/2021 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

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:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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	109	39,531		11,606	29.36%		3,124	4.43
2.	Psych	46	16,790		7,498	44.66%		1,614	4.65
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	14	7,000		1,987	28.39%			
6.	Coronary Care Unit								
7.	NICU	7	2,504		257	10.26%			
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				638				
22.	Total	176	65,825		21,986	33.40%		4,738	4.51
23.	Observation Bed Days				3,817				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				220			52	4.67
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				22				
6.	Coronary Care Unit								
7.	NICU				1				
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				41				
22.	Total				284	1.29%		52	4.67

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:	
15-0004		8017	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2021	To: 12/31/2021

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	6,848,654	19,100,363	0.358561	147,851		53,014	
2.	Recovery Room	501,120	2,536,585	0.197557	46,765		9,239	
3.	Delivery and Labor Room							
4.	Anesthesiology	4,890,525	6,865,313	0.712353	43,274		30,826	
5.	Radiology - Diagnostic	5,082,956	9,397,883	0.540862	66,775		36,116	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	719,132	2,207,747	0.325731	43,875		14,291	
8.	Laboratory	9,693,538	50,715,608	0.191135	445,298		85,112	
9.	Blood							
10.	Blood - Administration	49,373	973,030	0.050741	10,911		554	
11.	Intravenous Therapy	4,379,960	21,183,085	0.206767	103,224		21,343	
12.	Respiratory Therapy	4,035,164	7,616,330	0.529804	98,809		52,349	
13.	Physical Therapy	4,361,300	4,598,380	0.948443	19,240		18,248	
14.	Occupational Therapy	921,926	3,458,836	0.266542	18,514		4,935	
15.	Speech Pathology	899,416	1,424,170	0.631537	13,225		8,352	
16.	EKG	305,640	10,300,425	0.029673	99,169		2,943	
17.	EEG	229,739						
18.	Med. / Surg. Supplies	10,046,467	15,638,701	0.642411	139,689		89,738	
19.	Drugs Charged to Patients	40,062,514	274,934,124	0.145717	262,100		38,192	
20.	Renal Dialysis	2,281,315	1,602,535	1.423566	4,047		5,761	
21.	Ambulance							
22.	Open Heart Surgery							
23.	Outpatient Surgery	3,909,250	1,565,165	2.497660	26,407		65,956	
24.	Radiology Spec. Proc.	1,448,018	6,468,927	0.223842				
25.	Ultrasound	1,200,162	8,098,463	0.148196				
26.	Computer Tomography	2,294,582	35,311,683	0.064981	153,732		9,990	
27.	Bariatric Center							
28.	Pain Clinic							
29.	Orthopedics	110,092						
30.	Cardiovascular Serv.	2,568,533	15,337	167.472974				
31.	Cardiac Rehab	1,612,345	2,103,080	0.766659				
32.	Radiation Oncology	2,201,407	4,946	445.088354				
33.	MRI	750,223	6,006,573	0.124900	15,171		1,895	
34.	Psych Activity Ther.							
35.	Wound Care	1,577,302	1,366,520	1.154247				
36.	Inf/ Care Trans Ctr							
37.	Anticoagulation Clin	571,306	584,758	0.976996				
38.	Implants	1,927,437	3,017,207	0.638815				
39.	Cardiac Cath	1,054,409	9,754,165	0.108098	168,679		18,234	
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	47,317	158	299.474684				
44.	Emergency	12,209,877	75,294,620	0.162161	44,274		7,180	
45.	Observation	9,939,430	9,478,755	1.048601	30,460		31,940	
46.	Total				2,001,489		606,208	

* 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: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2021 To: 12/31/2021

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)	40,158,902			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	15,423			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,603.83			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	220			
3.	Program general inpatient routine cost (Line 1c X Line 2)	572,843			
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)	572,843			

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	7,987,970	1,987	4,020.12	22	88,443
9.	Coronary Care Unit					
10.	NICU	2,249,121	257	8,751.44	1	8,751
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	2,167,841	638	3,397.87	41	139,313
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					606,208
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,415,558

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

Preliminary

Medicare Provider Number:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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.	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:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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.	Open Heart Surgery							
23.	Outpatient Surgery							
24.	Radiology Spec. Proc.							
25.	Ultrasound							
26.	Computer Tomography							
27.	Bariatric Center							
28.	Pain Clinic							
29.	Orthopedics							
30.	Cardiovascular Serv.							
31.	Cardiac Rehab							
32.	Radiation Oncology							
33.	MRI							
34.	Psych Activity Ther.							
35.	Wound Care							
36.	Inf/ Care Trans Ctr							
37.	Anticoagulation Clin							
38.	Implants							
39.	Cardiac Cath							
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:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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.	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)							
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: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2021 To: 12/31/2021

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)	1,415,558	
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)	618	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,416,176	
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)	2,001,489	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	628,572	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU		
	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)	2,630,061	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,213,885
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: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2021 To: 12/31/2021

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)	1,416,176	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,416,176	
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)	1,416,176	

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:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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)	1,213,885
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) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(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: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2021 To: 12/31/2021

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:		Medicaid Provider Number:	
15-0004		8017	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2021	To: 12/31/2021

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							
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.	Open Heart Surgery							
23.	Outpatient Surgery							
24.	Radiology Spec. Proc.							
25.	Ultrasound							
26.	Computer Tomography							
27.	Bariatric Center							
28.	Pain Clinic							
29.	Orthopedics							
30.	Cardiovascular Serv.							
31.	Cardiac Rehab							
32.	Radiation Oncology							
33.	MRI							
34.	Psych Activity Ther.							
35.	Wound Care							
36.	Inf/ Care Trans Ctr							
37.	Anticoagulation Clin							
38.	Implants							
39.	Cardiac Cath							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	1,050,876	75,294,620	0.013957	44,274		618	
45.	Observation							
46.	Ancillary Total						618	

* 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:	15-0004	Medicaid Provider Number:	8017
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2021 To: 12/31/2021

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							
48.	Psych							
49.	Rehab							
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)							
68.	Ancillary Total (from line 46)						618	
69.	Total (Lines 67-68)						618	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 15-0004	Medicaid Provider Number: 8017
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2021 To: 12/31/2021

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	243		243
Newborn Days	41		41
Total Inpatient Revenue	2,630,061		2,630,061
Ancillary Revenue	2,001,489		2,001,489
Routine Revenue	628,572		628,572
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Adjusted the Part I-Hospital total A&P beds as Medicare report does not seem correct.

39531 total bed days A&P / 365 days/year = 109 total A&P beds

BHF Page 2 - combine the Program Psych and A&P days on as filed report as A&P; hopsital didn't file a separate Psych report

BHF Page 2 - Program discharges calculated so length of stay agrees with the XIX ave length of stay per W/S S-3

178 A&P + 22 ICU + 1 NICU + 42 Psych / 4.71 ave length of stay = 52 program discharges

BHF Page 3 - Reclassified the D&L I/P charges to Recovery Room as no cost/charge assoc with the D&L

BHF Page 3 - Reclassified the EEG I/P charges to EKG as no cost/charge assoc with the EEG

BHF Page 4 - Added the program psych days to line 2

BHF Page 4 - Moved the NICU days from CCU to NICU, Col B lines 9 and 10

BHF Page 6a & 6b - adjusted out professional fees as none on the IPCR

BHF Page 7 - Routine charges grouped on lines 10A and 10B; allowed as such; reasonable to W/S C, Part I, Col 8 and the IPCR

Psych days and charges reported on W/S C Part I and IPCR; but not filed separately by hospital and IPCR doesn't separate Psych costs on the IPCR; therefore file all as one report and combine A&P and Psych for prelim purposes.