

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: Methodist Medical Center of Illinois		Medicare Provider Number: 14-0209	
Street: 221 N E Glen Oak		Medicaid Provider Number: 16006	
City: Peoria	State: Illinois	Zip: 61636	
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
☐ XXXX XXXX Other (Specify)	☐ 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)

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐
☐ XXXX 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)) Methodist Medical Center of Il 16006 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: 14-0209		Medicaid Provider Number: 16006	
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	202	72,882		44,248	60.71%		11,788	4.42
2.	Psych	44	16,060		12,919	80.44%		1,898	6.81
3.	Rehab	13	4,745		4,052	85.40%		335	12.10
4.	Other (Sub)								
5.	Intensive Care Unit	14	7,350		4,803	65.35%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		3,004	68.58%			
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	20	7,300		4,701	64.40%			
22.	Total	305	112,717		73,727	65.41%		14,021	4.92
23.	Observation Bed Days				6,331				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				1,367			193	7.08
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
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				1,367	1.85%		193	7.08

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:	14-0209	Medicaid Provider Number:	16006
Program:	Medicaid-Hospital	Period Covered by Statement:	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) (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	36,102,065	158,998,332	0.227059				
2.	Recovery Room	5,061,761	42,337,096	0.119559				
3.	Delivery and Labor Room	2,963,852	12,467,419	0.237728				
4.	Anesthesiology	6,032,960	99,165,293	0.060837				
5.	Radiology - Diagnostic	11,592,812	53,159,442	0.218076	22,684		4,947	
6.	Radiology - Therapeutic	4,191,233	38,316,692	0.109384				
7.	Nuclear Medicine	2,198,342	8,610,655	0.255305				
8.	Laboratory	34,505,541	324,997,277	0.106172	471,962		50,109	
9.	Blood							
10.	Blood - Administration	1,737,541	8,073,009	0.215228				
11.	Intravenous Therapy	5,885,748	28,950,372	0.203305	15,903		3,233	
12.	Respiratory Therapy	2,632,773	32,506,472	0.080992	31,905		2,584	
13.	Physical Therapy	2,706,167	8,393,001	0.322431	2,984		962	
14.	Occupational Therapy	1,435,134	5,100,345	0.281380	2,488		700	
15.	Speech Pathology	1,041,595	3,597,159	0.289560				
16.	EKG	482,812	9,604,410	0.050270	21,511		1,081	
17.	EEG	1,515,231	7,470,822	0.202820	8,310		1,685	
18.	Med. / Surg. Supplies	1,993,933	63,210,636	0.031544				
19.	Drugs Charged to Patients	24,448,524	93,056,919	0.262727	38,487		10,112	
20.	Renal Dialysis	632,632	2,774,106	0.228049				
21.	Ambulance							
22.	Pain Clinic	413,013	1,540,494	0.268104				
23.	Northside Imaging	922,665	2,772,276	0.332819				
24.	Northside Mammography	458,100	1,952,297	0.234647				
25.	Northside Ultrasound	8,238	75,795	0.108688				
26.	Implant Devices	18,515,470	71,800,912	0.257872				
27.	Pulmonary Function	285,896	7,212,933	0.039637	194		8	
28.	Cardiac Cath	1,146,062	39,795,362	0.028799				
29.	CT Scan	1,291,511	80,180,958	0.016107	90,395		1,456	
30.	Northside CT	540,149	8,709,551	0.062018				
31.	MRI	1,194,203	23,726,494	0.050332	11,572		582	
32.	Northside MRI	677,119	9,815,129	0.068987				
33.	Cardiology	2,544,974	14,851,870	0.171357	3,715		637	
34.	Psych-Part Hospital	1,335,004	3,215,020	0.415240				
35.	GI	2,036,563	29,907,076	0.068096				
36.	Cardiac Rehab	984	460	2.139130				
37.	Hyperbaric Oxygen	668,050	2,236,498	0.298704				
38.	Other Clinics	7,305,718	39,583,498	0.184565				
39.	Chilli Family Psysic	12	86	0.139535				
40.	Physician Offices	15,731,883	56,797,089	0.276984				
41.	Endocrinology, Diabetic	1,230,103	4,704,246	0.261488				
42.	Wound Care Center	1,595,978	6,895,142	0.231464				
Outpatient Service Cost Centers								
43.	Clinic	6,385,426	32,416,286	0.196982	5,484		1,080	
44.	Emergency	12,305,681	111,018,786	0.110843	462,327		51,246	
45.	Observation	5,957,977	11,248,952	0.529647				
46.	Total				1,189,921		130,422	

* 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: 14-0209	Medicaid Provider Number: 16006
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)	47,598,818	12,326,684	3,785,946	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	50,579	12,919	4,052	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	941.08	954.15	934.34	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		1,367		
3.	Program general inpatient routine cost (Line 1c X Line 2)		1,304,323		
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)		1,304,323		

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	15,904,066	4,803	3,311.28		
9.	Coronary Care Unit					
10.	Surgical ICU	1,008,245	3,004	335.63		
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	3,390,393	4,701	721.21		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					130,422
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					1,434,745

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

PRELIMINARY

Medicare Provider Number:	14-0209	Medicaid Provider Number:	16006
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.	Surgical ICU						
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:	14-0209	Medicaid Provider Number:	16006
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.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI							
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices							
41.	Endocrinology, Diabetic							
42.	Wound Care Center							
	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:	14-0209	Medicaid Provider Number:	16006
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.	Surgical ICU							
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: 14-0209		Medicaid Provider Number: 16006	
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)	1,434,745	
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)	44,645	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	1,479,390	
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)	1,189,921	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	3,446,844	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	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)	4,636,765	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		3,157,375
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: 14-0209	Medicaid Provider Number: 16006
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)	1,479,390	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,479,390	
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)	1,479,390	

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:	14-0209	Medicaid Provider Number:	16006
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)	3,157,375
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: 14-0209	Medicaid Provider Number: 16006
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:	
14-0209		16006	
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	524,135	158,998,332	0.003296				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	144,069	53,159,442	0.002710	22,684		61	
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.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	Implant Devices							
27.	Pulmonary Function							
28.	Cardiac Cath							
29.	CT Scan							
30.	Northside CT							
31.	MRI							
32.	Northside MRI							
33.	Cardiology							
34.	Psych-Part Hospital							
35.	GI	123,030	29,907,076	0.004114				
36.	Cardiac Rehab							
37.	Hyperbaric Oxygen							
38.	Other Clinics							
39.	Chilli Family Psysic							
40.	Physician Offices	5,051,549	56,797,089	0.088940				
41.	Endocrinology, Diabetic	32,015	4,704,246	0.006806				
42.	Wound Care Center							
	Outpatient Ancillary Centers							
43.	Clinic	4,210,006	32,416,286	0.129873	5,484		712	
44.	Emergency	411,625	111,018,786	0.003708	462,327		1,714	
45.	Observation							
46.	Ancillary Total						2,487	

* 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:	14-0209	Medicaid Provider Number:	16006
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	1,242,192	50,579	24.56				
48.	Psych	398,361	12,919	30.84	1,367		42,158	
49.	Rehab	30,644	4,052	7.56				
50.	Other (Sub)							
51.	Intensive Care Unit	178,828	4,803	37.23				
52.	Coronary Care Unit							
53.	Surgical ICU	21,496	3,004	7.16				
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	33,845	4,701	7.20				
67.	Routine Total (lines 47-66)						42,158	
68.	Ancillary Total (from line 46)						2,487	
69.	Total (Lines 67-68)						44,645	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

PRELIMINARY

Medicare Provider Number: 14-0209	Medicaid Provider Number: 16006
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	1,367		1,367
Newborn Days			
Total Inpatient Revenue	4,636,765		4,636,765
Ancillary Revenue	1,189,921		1,189,921
Routine Revenue	3,446,844		3,446,844
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 2 - Agreed the hospital total beds and bed days to W/S S-3

BHF Page 2 - Reclassed the CCU info to Surgical ICU to agree with Medicare report

BHF Page 3 - Reclassed blood to blood admin

BHF Page 3 - Agreed the total cost in col 1 to W/S C Part I

BHF Page 3 - Other clinics contain lines 90.02, 90.04, 90.08-90.14 of W/S C, Part I of the Medicare report

BHF Page 4 - Line 1a and lines 8-23 agree with W/S C, Part I, Col 1 of the Medicare report

BHF Page 4 - Reclassed the CCU info to Surgical ICU per Medicare report

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