Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

Preliminary

Name of Hospital:		Medicare Provider Number:
Advocate Lutheran General Hospital		14-0223
Street:		**Medicaid Provider Number:**
1775 W. Dempster Street		16017
City:	**State:**	**Zip:**
Park Ridge	Illinois	60068
Period Covered by Statement:	**From:**	**To:**
	01/01/2023	12/31/2023

Type of Control

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

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)) Advocate Lutheran General H 16017 for the cost report beginning 01/01/2023 and ending 12/31/2023 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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	386	138,629		111,963	80.76%		24,308	5.27
2.	Psych	55	20,075		8,010	39.90%		1,157	6.92
3.	Rehab	45	16,425		11,775	71.69%		796	14.79
4.	Other (Sub)								
5.	Intensive Care Unit	23	8,395		7,294	86.89%			
6.	Coronary Care Unit	32	11,680		8,826	75.57%			
7.	Neonatal Care Unit								
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	46	16,790		4,920	29.30%			
22.	**Total**	**587**	**211,994**		**152,788**	**72.07%**		**26,261**	**5.63**
23.	Observation Bed Days				18,932				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,476			857	6.79
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				71				
6.	Coronary Care Unit				276				
7.	Neonatal Care Unit								
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				297				
22.	**Total**				**6,120**	**4.01%**		**857**	**6.79**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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	48,301,407	160,373,600	0.301181	2,156,105		649,378	
2.	Recovery Room	3,943,366	20,778,625	0.189780	160,475		30,455	
3.	Delivery and Labor Room	13,322,422	30,613,233	0.435185	891,615		388,017	
4.	Anesthesiology	2,965,418	73,559,318	0.040313	779,460		31,422	
5.	Radiology - Diagnostic	26,234,470	153,751,786	0.170629	1,315,975		224,543	
6.	Radiology - Therapeutic	7,965,273	67,981,115	0.117169	88,745		10,398	
7.	Nuclear Medicine	3,742,371	36,117,732	0.103616	615,510		63,777	
8.	Laboratory	46,441,260	273,188,624	0.169997	6,410,865		1,089,828	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,154,894	83,524,442	0.265250	1,766,175		468,478	
13.	Physical Therapy	21,534,831	76,631,565	0.281018	921,705		259,016	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	7,972,805	65,511,626	0.121701	868,360		105,680	
17.	EEG	3,238,785	26,263,664	0.123318	371,070		45,760	
18.	Med. / Surg. Supplies	56,394,195	101,978,200	0.553002	2,118,449		1,171,507	
19.	Drugs Charged to Patients	76,220,563	468,358,171	0.162740	12,031,446		1,957,998	
20.	Renal Dialysis	2,908,410	10,472,925	0.277708	205,500		57,069	
21.	Ambulance							
22.	CT Scan	12,810,609	273,769,267	0.046793	4,089,832		191,376	
23.	MRI	6,557,565	91,438,805	0.071715	1,042,371		74,754	
24.	Cardiac Cath	18,750,037	150,599,478	0.124503	3,532,015		439,746	
25.	Implants Charged	54,950,957	118,602,916	0.463319	1,754,640		812,958	
26.	ASC	8,536,242	54,666,209	0.156152	69,272		10,817	
27.	Neurology	2,504,887	5,474,945	0.457518	12,970		5,934	
28.	Behavioral Health	4,428,396	4,407,335	1.004779				
29.	Lithotripter	251,924	379,070	0.664584				
30.	GI Lab	10,677,178	77,403,413	0.137942	342,478		47,242	
31.	Cardiac Rehab	1,678,570	5,130,690	0.327163				
32.	Diabetes Care Center	391,456	110,130	3.554490				
33.	Outpatient Center	6,527,851	22,286,800	0.292902	2,350		688	
34.	Pain Clinic	959,724	4,068,562	0.235888				
35.	Wound Care Center	2,403,067	6,991,868	0.343695	116,755		40,128	
36.	Anti Coag Lab	972,760	1,358,820	0.715886				
37.	Allogeneic Stem Cell Acq	745,665	1,293,656	0.576401	80,153		46,200	
38.	Car-T Cells	2,586,295	5,415,908	0.477537				
39.	Crystal Lake Infusion	39,123,971	140,772,449	0.277923				
40.	Elgin Infusion	13,093,419	43,595,707	0.300337				
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	43,192,916	197,339,947	0.218876	2,089,080		457,249	
45.	Observation	23,555,573	74,289,948	0.317076	617,575		195,818	
46.	**Total**				**44,450,946**		**8,876,236**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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)	162,799,246	12,448,110	14,346,824	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	130,895	8,010	11,775	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,243.74	1,554.07	1,218.41	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,476			
3.	Program general inpatient routine cost (Line 1c X Line 2)	6,810,720			
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)	6,810,720			

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	20,205,522	7,294	2,770.16	71	196,681
9.	Coronary Care Unit	18,498,502	8,826	2,095.91	276	578,471
10.	Neonatal Care Unit					
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	2,234,919	4,920	454.25	297	134,912
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					8,876,236
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**16,597,020**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Neonatal Care Unit						
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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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.	Implants Charged							
26.	ASC							
27.	Neurology							
28.	Behavioral Health							
29.	Lithotripter							
30.	GI Lab							
31.	Cardiac Rehab							
32.	Diabetes Care Center							
33.	Outpatient Center							
34.	Pain Clinic							
35.	Wound Care Center							
36.	Anti Coag Lab							
37.	Allogeneic Stem Cell Acq							
38.	Car-T Cells							
39.	Crystal Lake Infusion							
40.	Elgin Infusion							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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.	Neonatal Care Unit							
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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)	16,597,020	
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)	1,435,002	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**18,032,022**	
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)	44,450,946	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	16,235,780	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	4,265,285	
	F. Coronary Care Unit	1,811,905	
	G. Neonatal Care Unit		
	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	1,251,791	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	68,015,707	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		49,983,685
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	18,032,022	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	18,032,022	
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)**	**18,032,022**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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)	49,983,685
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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
BHF Supplement No. 1

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number:	**Medicaid Provider Number:**
14-0223	**16017**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2023 To: 12/31/2023**

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

	Gross Routine Revenues	**Adults and Pediatrics**	**Sub I Psych**	**Sub II Rehab**	**Sub III Other (Sub)**
1.	(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:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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	4,833,643	160,373,600	0.030140	2,156,105		64,985	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	673,446	273,188,624	0.002465	6,410,865		15,803	
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.	Implants Charged							
26.	ASC							
27.	Neurology							
28.	Behavioral Health	593,000	4,407,335	0.134548				
29.	Lithotripter							
30.	GI Lab	1,098,659	77,403,413	0.014194	342,478		4,861	
31.	Cardiac Rehab							
32.	Diabetes Care Center							
33.	Outpatient Center							
34.	Pain Clinic							
35.	Wound Care Center							
36.	Anti Coag Lab							
37.	Allogeneic Stem Cell Acq							
38.	Car-T Cells							
39.	Crystal Lake Infusion							
40.	Elgin Infusion							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	3,201,743	197,339,947	0.016225	2,089,080		33,895	
45.	Observation							
46.	**Ancillary Total**						**119,544**	

* 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:	Medicaid Provider Number:
14-0223	16017
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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	29,420,142	130,895	224.76	5,476		1,230,786	
48.	Psych	583,806	8,010	72.88				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,779,892	7,294	244.02	71		17,325	
52.	Coronary Care Unit	2,153,649	8,826	244.01	276		67,347	
53.	Neonatal Care Unit							
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)**						**1,315,458**	
68.	**Ancillary Total (from line 46)**						**119,544**	
69.	**Total (Lines 67-68)**						**1,435,002**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-0223	16017	
Program:	Period Covered by Statement:	
Medicaid Hospital	From: 01/01/2023	To: 12/31/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	5,823		5,823
Newborn Days	297		297
Total Inpatient Revenue	68,025,022	(9,315)	68,015,707
Ancillary Revenue	44,460,261	(9,315)	44,450,946
Routine Revenue	23,564,761		23,564,761
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Adjusted the Part I-Hospital Total Bed Days Available to agree with W/S S-3 of the Medicare report
BHF Page 2 - Added the Part I-Hospital Observation days from W/S S-3 of the Medicare report
BHF Page 3 - Excluded $9,315 Cardiac Rehab program inpatient charges. This service is non-covered for IL Medicaid
BHF Page 4 & Supplemental 2b - Adjusted A&P, ICU, and Nursery costs with splits between Acute and
Children's facilities (see attached spreadsheet)
BHF Page 4 - Routine charges come from W/S C, Part I, Col 1 of the Medicare report; W/S D-1 included the RCE
Disallowance which is not allowable for cost reporting purposes
BHF Supplemental 2b - Allocated the A&P & ICU GME expenses between the Adult's & Children's cost reports
see attached spreadsheet