Hospital Statement of Cost

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

General Information

Preliminary - Revised #1

Name of Hospital: Riverside Medical Center		**Medicare Provider Number:** 14-0186
Street: 350 N. Wall Street		**Medicaid Provider Number:** 11006
City: Kankakee	**State:** Illinois	**Zip:** 60901
Period Covered by Statement:	**From:** 01/01/2016	**To:** 12/31/2016

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
	Church		Individual		State		Township
XXXX XXXX	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		DHS - Office of Rehabilitation Services
	Medicaid Sub I Psych		Medicaid Sub III Other		U of I - Division of Specialized Care for Children

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)) Riverside Medical Center 11006 for the cost report beginning 01/01/2016 and ending 12/31/2016 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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 - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	210	76,860		39,355	51.20%		10,554	4.14
2.	Psych	64	23,424		8,968	38.29%		1,008	8.90
3.	Rehab	30	10,980		8,137	74.11%		756	10.76
4.	Other (Sub)								
5.	Intensive Care Unit	18	6,588		4,358	66.15%			
6.	Coronary Care Unit	13	4,758						
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	18	6,588		2,463	37.39%			
22.	**Total**	**353**	**129,198**		**63,281**	**48.98%**		**12,318**	**4.94**
23.	Observation Bed Days				1,284				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				12,291			2,239	5.89
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				889				
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				502				
22.	**Total**				**13,682**	**21.62%**		**2,239**	**5.89**

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 - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	20,366,754	90,165,972	0.225881	7,799,167		1,761,684	
2.	Recovery Room	3,720,402	14,180,186	0.262366	928,603		243,634	
3.	Delivery and Labor Room	3,372,841	6,398,639	0.527119				
4.	Anesthesiology	1,921,398	31,123,460	0.061735	3,040,913		187,731	
5.	Radiology - Diagnostic	13,845,378	63,131,168	0.219311	912,869		200,202	
6.	Radiology - Therapeutic	5,126,165	14,882,793	0.344436	2,155		742	
7.	Nuclear Medicine	1,150,338	6,125,666	0.187790	137,810		25,879	
8.	Laboratory	14,239,515	114,051,177	0.124852	5,210,544		650,547	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	3,946,850	6,468,624	0.610153	62,277		37,998	
12.	Respiratory Therapy	4,140,523	23,849,901	0.173608	1,813,200		314,786	
13.	Physical Therapy	7,422,613	24,202,737	0.306685	303,027		92,934	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	5,211,008	22,672,325	0.229840	708,566		162,857	
17.	EEG							
18.	Med. / Surg. Supplies	1,239,013	11,208,402	0.110543				
19.	Drugs Charged to Patients	16,854,559	108,697,480	0.155059	4,730,893		733,568	
20.	Renal Dialysis	968,097	1,119,111	0.865059	54,850		47,448	
21.	Ambulance	5,128,772	5,648,065	0.908058	129,230		117,348	
22.	Cardiac Cath Lab	8,422,355	48,235,742	0.174608	2,501,136		436,718	
23.	CT Scan	2,563,234	57,324,231	0.044715	3,022,270		135,141	
24.	Ultrasound	1,879,868	13,355,405	0.140757	552,002		77,698	
25.	MRI	1,466,174	14,562,564	0.100681	560,315		56,413	
26.	Cardiac Rehab	1,008,188	1,162,846	0.867000				
27.	OP Psy/CDU	2,512,182	8,991,445	0.279397				
28.	RIMMS/Occ Health	858,388	1,332,875	0.644012				
29.	Diabetes	733,025	733,086	0.999917				
30.	Infusion	1,284,297	878,814	1.461398	233		341	
31.	Community Health	590,456	5,318,695	0.111015				
32.	RHC	366,885	484,037	0.757969				
33.	Implantable Devices	15,290,018	34,609,864	0.441782				
34.	Wound/Hyperbaric	1,369,545	3,445,999	0.397430	79,779		31,707	
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	9,942,224	74,847,088	0.132834	2,879,018		382,431	
45.	Observation	2,808,714	21,668,671	0.129621	135,242		17,530	
46.	**Total**				**35,564,099**		**5,715,337**	

* 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 - Revised #1

Medicare Provider Number: **14-0186**	**Medicaid Provider Number:** **11006**
Program: **Medicaid Hospital**	**Period Covered by Statement:** **From: 01/01/2016 To: 12/31/2016**

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)	28,105,488	6,649,695	6,013,410	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	40,639	8,968	8,137	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	691.59	741.49	739.02	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	12,291			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,500,333			
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)	8,500,333			

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	7,104,382	4,358	1,630.19	889	1,449,239
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	2,311,147	2,463	938.35	502	471,052
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					5,715,337
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**16,135,961**

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

Preliminary - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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.	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 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 - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	36,000	90,165,972	0.000399	7,799,167		3,112	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	511,191	31,123,460	0.016425	3,040,913		49,947	
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,200	23,849,901	0.000805	1,813,200		1,460	
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.	Cardiac Cath Lab							
23.	CT Scan							
24.	Ultrasound							
25.	MRI							
26.	Cardiac Rehab							
27.	OP Psy/CDU	67,319	8,991,445	0.007487				
28.	RIMMS/Occ Health	284,211	1,332,875	0.213232				
29.	Diabetes							
30.	Infusion							
31.	Community Health							
32.	RHC	14,098	484,037	0.029126				
33.	Implantable Devices							
34.	Wound/Hyperbaric							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	118,950	74,847,088	0.001589	2,879,018		4,575	
45.	Observation							
46.	**Ancillary Total**						**59,094**	

* 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 - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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	97,277	40,639	2.39	12,291		29,375	
48.	Psych	15,343	8,968	1.71				
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)**						**29,375**	
68.	**Ancillary Total (from line 46)**						**59,094**	
69.	**Total (Lines 67-68)**						**88,469**	

Hospital Statement of Cost
Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	16,135,961	
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)	88,469	
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)	351,463	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**16,575,893**	
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)	35,564,099	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	9,708,759	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	1,343,081	
	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	1,432,200	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	48,048,139	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		31,472,246
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 - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	16,575,893	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	16,575,893	
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)**	**16,575,893**	

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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary - Revised #1

Medicare Provider Number:	Medicaid Provider Number:
14-0186	11006
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2016 To: 12/31/2016

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)	31,472,246
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 **BHF Supplement No. 1**

Teaching Physicians / Routine Services Questionnaire

Preliminary - Revised #1

Medicare Provider Number:	**Medicaid Provider Number:**
14-0186	**11006**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

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 - Revised #1

Medicare Provider Number:	**Medicaid Provider Number:**
14-0186	**11006**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

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	56,137	90,165,972	0.000623	7,799,167		4,859	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	28,443	63,131,168	0.000451	912,869		412	
6.	Radiology - Therapeutic	75,597	14,882,793	0.005079	2,155		11	
7.	Nuclear Medicine	34,056	6,125,666	0.005560	137,810		766	
8.	Laboratory	22,829	114,051,177	0.000200	5,210,544		1,042	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	56,137	22,672,325	0.002476	708,566		1,754	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Cath Lab	160,551	48,235,742	0.003328	2,501,136		8,324	
23.	CT Scan							
24.	Ultrasound							
25.	MRI							
26.	Cardiac Rehab							
27.	OP Psy/CDU							
28.	RIMMS/Occ Health							
29.	Diabetes							
30.	Infusion							
31.	Community Health							
32.	RHC							
33.	Implantable Devices							
34.	Wound/Hyperbaric							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency	49,400	74,847,088	0.000660	2,879,018		1,900	
45.	Observation							
46.	**Ancillary Total**						**19,068**	

* 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 - Revised #1

Medicare Provider Number:	**Medicaid Provider Number:**
14-0186	**11006**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

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	977,526	40,639	24.05	12,291		295,599	
48.	Psych	154,186	8,968	17.19				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	180,385	4,358	41.39	889		36,796	
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)**						**332,395**	
68.	**Ancillary Total (from line 46)**						**19,068**	
69.	**Total (Lines 67-68)**						**351,463**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary - Revised #1

Medicare Provider Number:	**Medicaid Provider Number:**
14-0186	**11006**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2016 To: 12/31/2016**

Inpatient Reconciliation	**Provider's Records**	**Adjustments**	**Audited Cost Report**
Adult Days	13,180		13,180
Newborn Days	502		502
Total Inpatient Revenue	48,070,643	(22,504)	48,048,139
Ancillary Revenue	35,586,603	(22,504)	35,564,099
Routine Revenue	12,484,040		12,484,040
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs for Observation were adjusted to the as filed W/S C Part 1, column 1.
BHF Page 3 - Total charges agree with as filed W/S C Part 1, column 8
Adjusted GME costs to agree with W/S B Part 1, column 25.
BHF Page 3 - Excluded program Cardiac Rehab charges of $22,504 as these charges are non-covered for Illinois Medicaid

BHF Supp. No 2(a) and (b)- Adjusted figures to agree with W/S B, Part I,Col. 25.

BHF Page 4 - Adults & Peds costs from W/S C, Column 1 are allocated between acute and Psych based upon split days from provider.
BHF Supp. No 2(b) - GME costs from W/S B Column 25 are allocated between Acute & Psych. There were GME costs in both areas in prior year.