

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: CGH Medical Center		Medicare Provider Number: 14-0043
Street: 100 East Lefevre Road		Medicaid Provider Number: 19010
City: Sterling	State: Illinois	Zip: 61081
Period Covered by Statement:	From: 05/01/2017	To: 04/30/2018

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input style="border: 1px solid black; padding: 2px;" type="checkbox"/> XXXX XXXX City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

Type of Hospital

<input style="border: 1px solid black; padding: 2px;" type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify) _____

Health Care Program

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input style="border: 1px solid black; padding: 2px;" type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab _____	<input type="checkbox"/> _____ _____
<input type="checkbox"/> Medicaid Sub I Psych _____	<input type="checkbox"/> Medicaid Sub III Other _____	<input type="checkbox"/> _____ _____

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)) CGH Medical Center 19010 for the cost report beginning 05/01/2017 and ending 04/30/2018 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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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	84	30,660		11,617	37.89%		4,079	3.19
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	8	2,920		1,391	47.64%			
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	6	2,190		1,009	46.07%			
22.	Total	98	35,770		14,017	39.19%		4,079	3.19
23.	Observation Bed Days				3,392				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,276			542	2.49
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				74				
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				389				
22.	Total				1,739	12.41%		542	2.49

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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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	5,608,840	46,210,133	0.121377	1,878,005	6,481,961	227,947	786,761
2.	Recovery Room	2,558,860	8,937,796	0.286297	201,099	1,796,302	57,574	514,276
3.	Delivery and Labor Room	2,179,604	6,220,298	0.350402	1,474,724		516,746	
4.	Anesthesiology	223,417	17,483,230	0.012779	764,806	2,287,169	9,773	29,228
5.	Radiology - Diagnostic	5,195,576	30,015,146	0.173098	340,751	5,137,893	58,983	889,359
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	1,142,826	13,269,549	0.086124	104,908	1,360,438	9,035	117,166
8.	Laboratory	8,617,445	102,028,123	0.084461	2,077,259	8,277,205	175,447	699,101
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	649,483	5,702,605	0.113892				
12.	Respiratory Therapy	2,019,200	7,784,983	0.259371	329,021	631,942	85,339	163,907
13.	Physical Therapy	715,021	1,453,288	0.492002	59,514	8,055	29,281	3,963
14.	Occupational Therapy	162,802	258,883	0.628863	9,682	639	6,089	402
15.	Speech Pathology	345,035	477,896	0.721988	2,417	15,080	1,745	10,888
16.	EKG	2,061,701	23,233,398	0.088739	336,444	10,699,268	29,856	949,442
17.	EEG	567,823	5,345,364	0.106227	5,512	63,159	586	6,709
18.	Med. / Surg. Supplies	18,493,458	21,421,177	0.863326	855,269	1,293,865	738,376	1,117,027
19.	Drugs Charged to Patients	27,512,911	64,121,304	0.429076	1,494,488	3,092,645	641,249	1,326,980
20.	Renal Dialysis	251,547	413,296	0.608636				
21.	Ambulance	3,017,432	5,834,810	0.517143				
22.	Pain Management	564,990	5,442,630	0.103808				
23.	Ultrasound	1,401,685	14,764,218	0.094938				
24.	CT Scan	2,148,500	60,853,272	0.035306	850,248	10,183,251	30,019	359,530
25.	MRI	1,252,230	19,182,544	0.065280	74,430	3,559,024	4,859	232,333
26.	GI Lab	2,715,265	25,635,525	0.105918	171,934	2,536,708	18,211	268,683
27.	Diabetic Education	529,351	451,756	1.171763				
28.	Home Infusion Therapy	203,580	404,441	0.503361				
29.	Cardiac Cath	2,857,954	20,170,161	0.141692	443,429	756,779	62,830	107,230
30.	Hyperb. Oxygen Ther	1,306,587	13,463,105	0.097049				
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	23,067,978	43,336,406	0.532300	12,776	15,085	6,801	8,030
44.	Emergency	8,566,045	53,845,855	0.159085	33,598	15,071,355	5,345	2,397,627
45.	Observation	3,548,632	6,589,903	0.538495	13,327	1,377,801	7,177	741,939
46.	Total				11,533,641	74,645,624	2,723,268	10,730,581

* 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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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)	17,739,447			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	15,009			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,181.92			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,276			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,508,130			
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)	1,508,130			

Line No.	Description	Total Dept. Costs	Total Days	Average	Program Days	Program Cost
		(CMS 2552-10, W/S C, Pt. 1, Col. 1)	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	Per Diem (Col. A / Col. B)	(BHF Page 2, Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	3,558,007	1,391	2,557.88	74	189,283
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	1,225,313	1,009	1,214.38	389	472,394
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,723,268
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					4,893,075

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

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient (5A)	Outpatient (5B)	Inpatient (6A)	Outpatient (6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	Total (Sum of Lines 22 and 26)								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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 Management							
23.	Ultrasound							
24.	CT Scan							
25.	MRI							
26.	GI Lab							
27.	Diabetic Education							
28.	Home Infusion Therapy							
29.	Cardiac Cath							
30.	Hyperb. Oxygen Ther							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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

Preliminary

Medicare Provider Number: 14-0043		Medicaid Provider Number: 19010	
Program: Medicaid Hospital		Period Covered by Statement: From: 05/01/2017 To: 04/30/2018	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		10,730,581
2.	Inpatient Operating Services (BHF Page 4, Line 25)	4,893,075	
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)		
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	4,893,075	10,730,581
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	31.00%	69.00%

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	11,533,641	74,645,624
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,607,497	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	331,816	
	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	1,098,925	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	15,571,879	74,645,624
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		74,593,847
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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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)	4,893,075	10,730,581
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	4,893,075	10,730,581
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)	4,893,075	10,730,581

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.

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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)	74,593,847
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)		
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)
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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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

Part A. Cost of Physicians Direct Medical and Surgical Services

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

Part B. Program Data

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

Part C. Program Cost

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

Part II - Routine Services Questionnaire

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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.	Pain Management							
23.	Ultrasound							
24.	CT Scan							
25.	MRI							
26.	GI Lab							
27.	Diabetic Education							
28.	Home Infusion Therapy							
29.	Cardiac Cath							
30.	Hyperb. Oxygen Ther							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary 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 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: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

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.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

**Hospital Statement of Cost
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 14-0043	Medicaid Provider Number: 19010
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2017 To: 04/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,350		1,350
Newborn Days	389		389
Total Inpatient Revenue	15,571,879		15,571,879
Ancillary Revenue	11,533,641		11,533,641
Routine Revenue	4,038,238		4,038,238
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue	74,645,623	1	74,645,624
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Excluded Home Health O/P revenue of \$108,610 as non-covered by Illinois Medicaid for a hospital cost report.

Provider did not break down program routine charges by category.

Calculated based on C pt 1 chgs x (prgm days Medicaid rpt. / total days S-3 pt 1)

ICU - \$7,008,627 x (135 / 1,391) = \$680,205

A & P - \$29,645,413 x (1,470 / 11,777+3,392) = \$2,872,883

Nursery - \$3,056,924 x (573 / 1,009) = \$1,735,994

(These totals tie to the breakdowns used in the 2015 report.)