Hospital Statement of Cost

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

General Information

Preliminary - Revised 9/19/19 - day and charge adjustment

Name of Hospital: Sts. Mary & Elizabeth Medical Center			**Medicare Provider Number:** 14-0180
Street: 2233 West Division Street			**Medicaid Provider Number:** 3054
City: Chicago	**State:** Illinois	**Zip:** 60622	
Period Covered by Statement:	**From:** 01/01/2018	**To:** 06/30/2018	

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)) Sts. Mary & Elizabeth Medical 3054 for the cost report beginning 01/01/2018 and ending 06/30/2018 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):

Name (Typewritten)

Title Date

Firm

Telephone Number

Email Address

Signed (Officer or Administrator of Provider(s)):

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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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	194	35,114		20,832	59.33%		5,720	4.05
2.	Psych	164	29,684		21,962	73.99%		3,130	7.02
3.	Rehab	15	2,715		2,167	79.82%		175	12.38
4.	Other (Sub)								
5.	Intensive Care Unit	26	4,706		2,359	50.13%			
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				1,545				
22.	**Total**	**399**	**72,219**		**48,865**	**67.66%**		**9,025**	**5.24**
23.	Observation Bed Days				2,264				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				2,530			513	5.25
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				163				
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				637				
22.	**Total**				**3,330**	**6.81%**		**513**	**5.25**

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 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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	9,421,894	72,348,558	0.130229	1,974,386		257,122	
2.	Recovery Room	1,043,728	11,282,063	0.092512	1,136,353		105,126	
3.	Delivery and Labor Room	2,448,573	3,897,183	0.628293	710,450		446,371	
4.	Anesthesiology	285,926	13,961,848	0.020479	839,478		17,192	
5.	Radiology - Diagnostic	4,314,014	42,203,615	0.102219	681,187		69,630	
6.	Radiology - Therapeutic	422,415	5,798,287	0.072852	235,399		17,149	
7.	Nuclear Medicine							
8.	Laboratory	10,587,947	73,424,084	0.144203	5,302,823		764,683	
9.	Blood							
10.	Blood - Administration	91,459	2,251,097	0.040629	101,492		4,124	
11.	Intravenous Therapy				615,703			
12.	Respiratory Therapy	1,884,382	14,727,227	0.127952	1,084,330		138,742	
13.	Physical Therapy	2,953,161	15,292,184	0.193116	186,908		36,095	
14.	Occupational Therapy	1,058,147	6,669,125	0.158664	118,744		18,840	
15.	Speech Pathology	280,708	682,585	0.411243	88,812		36,523	
16.	EKG	1,462,681	24,499,208	0.059703	910,346		54,350	
17.	EEG	333,023	652,764	0.510174	6,344		3,237	
18.	Med. / Surg. Supplies	9,251,098	25,194,331	0.367190	2,217,739		814,332	
19.	Drugs Charged to Patients	8,785,132	69,426,854	0.126538	4,346,299		549,972	
20.	Renal Dialysis	746,687	5,227,354	0.142842	312,906		44,696	
21.	Ambulance							
22.	Cardiac Rehab	265,489	327,593	0.810423				
23.	ASC							
24.	Mental Health	4,393,494	6,275,448	0.700108	1,481		1,037	
25.	Cardiac Cath	851,479	8,836,959	0.096354				
26.	CT Scan	811,681	28,881,784	0.028104	1,012,441		28,454	
27.	MRI	512,503	7,893,437	0.064928	222,695		14,459	
28.	Implants	6,443,755	19,574,386	0.329193				
29.	Outpatient Oncology	8,016,014	42,983,305	0.186491				
30.	Blood Clotting	46,803	53,911	0.868153				
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	2,183,585	3,237,366	0.674494	4,873		3,287	
44.	Emergency	13,865,142	82,504,743	0.168053	588,097		98,831	
45.	Observation	2,467,420	15,109,707	0.163300	62,584		10,220	
46.	**Total**				**22,761,870**		**3,534,472**	

* 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 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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)	25,171,209	23,326,752	1,760,975	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	23,096	21,962	2,167	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,089.85	1,062.14	812.63	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	2,530			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,757,321			
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)	2,757,321			

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	5,431,788	2,359	2,302.58	163	375,321
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	923,871	1,545	597.97	637	380,907
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					3,534,472
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**7,048,021**

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

Preliminary - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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.	Cardiac Rehab							
23.	ASC							
24.	Mental Health							
25.	Cardiac Cath							
26.	CT Scan							
27.	MRI							
28.	Implants							
29.	Outpatient Oncology							
30.	Blood Clotting							
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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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)	7,048,021	
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)	312,992	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**7,361,013**	
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)	22,761,870	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	8,635,649	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	974,576	
	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	3,232,274	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	35,604,369	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		28,243,356
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 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:		
14-0180	3054		
Program:	**Period Covered by Statement:**		
Medicaid Hospital	From: 01/01/2018	To:	06/30/2018

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)	7,361,013	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	7,361,013	
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)**	**7,361,013**	

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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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)	28,243,356
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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	**Medicaid Provider Number:**
14-0180	**3054**
Program:	**Period Covered by Statement:**
Medicaid Hospital	**From: 01/01/2018 To: 06/30/2018**

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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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.	Cardiac Rehab							
23.	ASC							
24.	Mental Health							
25.	Cardiac Cath							
26.	CT Scan							
27.	MRI							
28.	Implants							
29.	Outpatient Oncology							
30.	Blood Clotting							
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 - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

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	2,145,972	23,096	92.92	2,530		235,088	
48.	Psych	1,827,273	21,962	83.20				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	229,716	2,359	97.38	163		15,873	
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	150,451	1,545	97.38	637		62,031	
67.	**Routine Total (lines 47-66)**						**312,992**	
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**						**312,992**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary - Revised 9/19/19 - day and charge adjustment

Medicare Provider Number:	Medicaid Provider Number:
14-0180	3054
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 01/01/2018 To: 06/30/2018

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	7,084	(4,391)	2,693
Newborn Days	838	(201)	637
Total Inpatient Revenue	39,541,007	(3,936,638)	35,604,369
Ancillary Revenue	23,641,151	(879,281)	22,761,870
Routine Revenue	15,899,856	(3,057,357)	12,842,499
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

FY18 is the first year the provider was Medicare certified for a Psych DPU. In the past, a portion of the A&P was allocated to a non-DPU Psych in the cost report. Due to the number of days billed as psych to Medicaid (both distinct and non-distinct) it is still necessary to allocated a portion of the A&P days into a combined psych unit. In order to accomplish this, the prior year was used as a basis to adjust days for both total and Medicaid, keeping the total of each the same, but apportioned differently in each category. After a target number of days was calculated, a paid claims report was used as a basis for charge and day detail. The report was then apportioned to the total the provider filed to protect the integrity of the filed days (in total). Please review the day and cost allocation spreadsheets as well as the charge spreadsheet as background for the basis of these reports.

BHF Page 3 - Removed filed Cardiac Rehab charges of $4,081. Cardiac Rehab is non covered for Illinois Medicaid.