

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: Saint James Hospital | | Medicare Provider Number: 14-0161 | |
| Street: 2500 W. Reynolds Street. | | Medicaid Provider Number: 16010 | |
| City: Pontiac | State: Illinois | Zip: 61764 | |
| Period Covered by Statement: | From: 10/01/2018 | To: 09/30/2019 | |

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 type="checkbox"/> 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 type="checkbox"/> 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 type="checkbox"/> 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)) Saint James Hospital 16010 for the cost report beginning 10/01/2018 and ending 09/30/2019 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.

Preliminary

| | |
|--------------------------------------|-----------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| 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 |
|------------------------|-----------------------|----------------------|--------------------------|-------------------------|--------------------------------------------------|-----------------------------------------------------|----------------------------------------|---------------------------------------------------------|-----------------------------------------------------|
| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Part I-Hospital | | | | | | | | | |
| 1. | Adults and Pediatrics | 37 | 13,505 | | 4,923 | 36.45% | | 1,780 | 3.29 |
| 2. | Psych | | | | | | | | |
| 3. | Rehab | | | | | | | | |
| 4. | Other (Sub) | | | | | | | | |
| 5. | Intensive Care Unit | 5 | 1,825 | | 935 | 51.23% | | | |
| 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 | 9 | 3,285 | | 408 | 12.42% | | | |
| 22. | Total | 51 | 18,615 | | 6,266 | 33.66% | | 1,780 | 3.29 |
| 23. | Observation Bed Days | | | | 1,099 | | | | |

| Part II-Program | | | | | | | | | |
|------------------------|-----------------------|-----|-----|-----|------------|--------------|-----|-----------|-------------|
| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| 1. | Adults and Pediatrics | | | | 105 | | | 61 | 2.23 |
| 2. | Psych | | | | | | | | |
| 3. | Rehab | | | | | | | | |
| 4. | Other (Sub) | | | | | | | | |
| 5. | Intensive Care Unit | | | | 31 | | | | |
| 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 | | | | 101 | | | | |
| 22. | Total | | | | 237 | 3.78% | | 61 | 2.23 |

| Line No. | Part III - Outpatient Statistics - Occasions of Service | Program | Total Hospital |
|----------|---------------------------------------------------------|---------|----------------|
| 1. | Total Outpatient Occasions of Service | | |

Preliminary

| | |
|---------------------------------------------|-------------------------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| 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 (4) | Total Billed O/P Charges (Gross) for Health Care Program Patients (5) | I/P Expenses Applicable to Health Care Program (Col. 3 X 4) (6) | O/P Expenses Applicable to Health Care Program (Col. 3 X 5) (7) |
|----------------------------------------|--------------------------------|----------------------------------------------------------|-------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------|
| | | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| 1. | Operating Room | 4,664,851 | 28,709,916 | 0.162482 | 365,023 | | 59,310 | |
| 2. | Recovery Room | | | | | | | |
| 3. | Delivery and Labor Room | | | | | | | |
| 4. | Anesthesiology | 856,363 | 3,643,293 | 0.235052 | 36,232 | | 8,516 | |
| 5. | Radiology - Diagnostic | 1,701,541 | 8,058,484 | 0.211149 | 27,139 | | 5,730 | |
| 6. | Radiology - Therapeutic | | | | | | | |
| 7. | Nuclear Medicine | 440,978 | 3,438,518 | 0.128247 | 72,164 | | 9,255 | |
| 8. | Laboratory | 3,428,149 | 41,743,318 | 0.082124 | 279,257 | | 22,934 | |
| 9. | Blood | | | | | | | |
| 10. | Blood - Administration | 147,248 | 938,888 | 0.156832 | 14,702 | | 2,306 | |
| 11. | Intravenous Therapy | 290,644 | 756,987 | 0.383948 | 7,145 | | 2,743 | |
| 12. | Respiratory Therapy | 909,071 | 3,327,481 | 0.273201 | 35,677 | | 9,747 | |
| 13. | Physical Therapy | 1,617,913 | 4,387,282 | 0.368773 | 11,065 | | 4,080 | |
| 14. | Occupational Therapy | 589,593 | 2,661,885 | 0.221495 | 9,212 | | 2,040 | |
| 15. | Speech Pathology | 447,904 | 898,768 | 0.498353 | 7,126 | | 3,551 | |
| 16. | EKG | 458,586 | 6,858,787 | 0.066861 | 18,234 | | 1,219 | |
| 17. | EEG | 507,639 | 2,327,310 | 0.218123 | | | | |
| 18. | Med. / Surg. Supplies | 985,611 | 6,226,038 | 0.158305 | 265,711 | | 42,063 | |
| 19. | Drugs Charged to Patients | 3,688,399 | 21,119,014 | 0.174648 | 249,070 | | 43,500 | |
| 20. | Renal Dialysis | | | | | | | |
| 21. | Ambulance | | | | | | | |
| 22. | Ultrasound | 510,733 | 5,273,033 | 0.096858 | | | | |
| 23. | CT Scan | 912,476 | 24,217,816 | 0.037678 | | | | |
| 24. | MRI | 740,659 | 8,509,055 | 0.087044 | | | | |
| 25. | Implant Devices Chrg. | 1,944,975 | 9,957,985 | 0.195318 | | | | |
| 26. | Diabetes Services | 141,485 | 151,760 | 0.932294 | | | | |
| 27. | Mammography | 311,909 | 2,895,543 | 0.107720 | | | | |
| 28. | Cardiac Rehab | 217,335 | 583,953 | 0.372179 | | | | |
| 29. | Other | | | | | | | |
| 30. | Other | | | | | | | |
| 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 | 439,141 | 820,123 | 0.535457 | | | | |
| 44. | Emergency | 4,601,020 | 19,246,444 | 0.239058 | 16,976 | | 4,058 | |
| 45. | Observation | 1,672,700 | 3,485,699 | 0.479875 | 9,958 | | 4,779 | |
| 46. | Total | | | | 1,424,691 | | 225,831 | |

* 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.

Preliminary

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|--------------------------------------|-----------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

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) | 9,165,580 | | | |
| b) | Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8) | 6,022 | | | |
| c) | Adjusted general inpatient routine service cost per diem (Line 1a / 1b) | 1,522.02 | | | |
| 2. | Program general inpatient routine days (BHF Page 2, Part II, Col. 4) | 105 | | | |
| 3. | Program general inpatient routine cost (Line 1c X Line 2) | 159,812 | | | |
| 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) | 159,812 | | | |

| 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 | 2,354,947 | 935 | 2,518.66 | 31 | 78,078 |
| 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 | 197,976 | 408 | 485.24 | 101 | 49,009 |
| 24. | Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46) | | | | | 225,831 |
| 25. | Total Program Inpatient Operating Costs (Sum of Lines 7 through 24) | | | | | 512,730 |

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

Preliminary

| | |
|---------------------------------------------|-------------------------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| 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) | | | | | | | | |

Preliminary

| | |
|---------------------------------------------|-------------------------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| Line No. | Cost Centers | Professional Component | Total Dept. Charges | Ratio of Professional | Inpatient Program | Outpatient Program | Inpatient Program | Outpatient Program |
|-----------------------------------|---------------------------|----------------------------------|--------------------------------------|------------------------------|------------------------------|------------------------------|--------------------------------------|--------------------------------------|
| | | (CMS 2552-10, W/S A-8-2, Col. 4) | (CMS 2552-10, W/S C, Pt. 1, Col. 8)* | to Charges (Col. 1 / Col. 2) | Charges (BHF Page 3, Col. 4) | Charges (BHF Page 3, Col. 5) | Expenses for H B P (Col. 3 X Col. 4) | 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 | 1,060,141 | 3,643,293 | 0.290984 | 36,232 | | 10,543 | |
| 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. | Ultrasound | | | | | | | |
| 23. | CT Scan | | | | | | | |
| 24. | MRI | | | | | | | |
| 25. | Implant Devices Charg. | | | | | | | |
| 26. | Diabetes Services | | | | | | | |
| 27. | Mammography | | | | | | | |
| 28. | Cardiac Rehab | | | | | | | |
| 29. | Other | | | | | | | |
| 30. | Other | | | | | | | |
| 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 | 2,232,493 | 19,246,444 | 0.115995 | 16,976 | | 1,969 | |
| 45. | Observation | | | | | | | |
| 46. | Ancillary Total | | | | | | 12,512 | |

* 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.

Preliminary

| | |
|--------------------------------------|-----------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| Line No. | Cost Centers | Professional Component | Total Days Including Private | Professional Component Cost Per Diem | Program Days Including Private | Outpatient Program Charges | Inpatient Program Expenses | Outpatient Program Expenses |
|------------------------------|---------------------------------------|----------------------------------|--------------------------------------|--------------------------------------|--------------------------------|----------------------------|----------------------------|-----------------------------|
| | | (CMS 2552-10, W/S A-8-2, Col. 4) | (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) | (Col. 1 / Col. 2) | (BHF Pg. 2 Pt. II, Col. 4) | (BHF Page 3, Col. 5) | (Col. 3 X Col. 4) | (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) | | | | | | 12,512 | |
| 69. | Total (Lines 67-68) | | | | | | 12,512 | |

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

| Medicare Provider Number: 14-0161 | | Medicaid Provider Number: 16010 | |
|---------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------|
| Program: Medicaid Hospital | | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 | |
| Line No. | Reasonable Cost | Program Inpatient | Program Outpatient |
| | | (1) | (2) |
| 1. | Ancillary Services (BHF Page 3, Line 46, Col. 7) | | |
| 2. | Inpatient Operating Services (BHF Page 4, Line 25) | 512,730 | |
| 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) | 12,512 | |
| 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) | 525,242 | |
| 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 | Program Outpatient |
|----------|-------------------------------------------------------------------------------------------------------|-------------------|--------------------|
| | | (1) | (2) |
| 9. | Ancillary Services (See Instructions) | 1,424,691 | |
| 10. | Inpatient Routine Services (Provider's Records) | | |
| | A. Adults and Pediatrics | 254,647 | |
| | B. Psych | | |
| | C. Rehab | | |
| | D. Other (Sub) | | |
| | E. Intensive Care Unit | 132,247 | |
| | 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 | 36,473 | |
| 11. | Services of Teaching Physicians (Provider's Records) | | |
| 12. | Total Charges for Patient Services (Sum of Lines 9 through 11) | 1,848,058 | |
| 13. | Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) | | 1,322,816 |
| 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) | | |

Preliminary

| | |
|--------------------------------------|-----------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| 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) | 525,242 | |
| 2. | Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2) | | |
| 3. | Total Current Cost Reporting Period Cost (Line 1 Minus Line 2) | 525,242 | |
| 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) | 525,242 | |

| 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: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

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) | 1,322,816 |
| 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 (4) | Sum of Columns 1 - 4 (5) |
|----------|-------------------------------------------------------------------------|-----------------------------------|-----|-----|-----------------------------------|--------------------------|
| | | 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) (1) | Inpatient | | Outpatient | |
|----------|-----------------------------------|----------------------------------------|------------|-------------------------|------------|-------------------------|
| | | | Ratio (2A) | Amount (Col. 1x2A) (2B) | Ratio (3A) | Amount (Col. 1x3A) (3B) |
| | | | (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) | | | | | |

Teaching Physicians / Routine Services Questionnaire

Preliminary

| | |
|--------------------------------------|-----------------------------------------------------------------|
| Medicare Provider Number: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

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 | Sub I | Sub II | Sub III |
|------------------------------------------------------------------------------|---------|-------|--------|-------------|
| | Service | Psych | Rehab | 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 | Sub I | Sub II | Sub III |
|---------------------------------------------------------------------------------|---------|-------|--------|-------------|
| | Service | Psych | Rehab | 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 | Sub I | Sub II | Sub III |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|--------|-------------|
| | Pediatrics | Psych | Rehab | 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: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| Line No. | Cost Centers | G M E | Total Dept. | Ratio of | Inpatient | Outpatient | Inpatient | Outpatient |
|-------------------------------------|---------------------------|----------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| | | Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25) | Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* | G M E Cost to Charges (Col. 1 / Col. 2) | Program Charges (BHF Page 3, Col. 4) | Program Charges (BHF Page 3, Col. 5) | Program Expenses for G M E (Col. 3 X Col. 4) | 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. | Ultrasound | | | | | | | |
| 23. | CT Scan | | | | | | | |
| 24. | MRI | | | | | | | |
| 25. | Implant Devices Charg. | | | | | | | |
| 26. | Diabetes Services | | | | | | | |
| 27. | Mammography | | | | | | | |
| 28. | Cardiac Rehab | | | | | | | |
| 29. | Other | | | | | | | |
| 30. | Other | | | | | | | |
| 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: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| Line No. | Cost Centers | G M E | Total Days | GME | Program | Outpatient | Inpatient | Outpatient |
|------------------------------|---------------------------------------|----------------------------------------------------|---------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| | | Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25) | Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8) | Cost Per Diem (Col. 1 / Col. 2) | Days Including Private (BHF Pg. 2 Pt. II, Col. 4) | Program Charges (BHF Page 3, Col. 5) | Program Expenses for G M E (Col. 3 X Col. 4) | 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: 14-0161 | Medicaid Provider Number: 16010 |
| Program: Medicaid Hospital | Period Covered by Statement: From: 10/01/2018 To: 09/30/2019 |

| Inpatient Reconciliation | Provider's Records | Adjustments | Audited Cost Report |
|------------------------------------|--------------------|-------------|---------------------|
| Adult Days | 136 | | 136 |
| Newborn Days | 101 | | 101 |
| Total Inpatient Revenue | 1,848,058 | | 1,848,058 |
| Ancillary Revenue | 1,424,691 | | 1,424,691 |
| Routine Revenue | 423,367 | | 423,367 |
| Inpatient Received and Receivable | | | |
| Outpatient Reconciliation | | | |
| Outpatient Occasions of Service | | | |
| Total Outpatient Revenue | | | |
| Outpatient Received and Receivable | | | |

Notes:

BHF Page 2, Part I - Removed Labor & Delivery Days from A&P Inpatient Days and Discharges

BHF Page 6 - Adjusted Professional Component to agree with filed Medicare Report W/S A-8-2 but only for the Anesthesiology, EEG and Emergency Cost Centers that were claimed. Provider reported Prof Fees for A&P and Laboratory on Medicare Report but did not claim them on cost report.

BHF Page 3 - Reclassed Blood to Blood Administration. Blood not covered by Illinois Medicaid

BHF Page 3 - Combined Program Inpatient Charges for Operating Room, Recovery Room and Delivery and Labor Room into Operating Room

BHF Page 3 - Combined Program Inpatient Charges for Radiology-Therapeutic and Nuclear Medicine into Nuclear Medicine
