

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: Trinity Medical Center		Medicare Provider Number: 14-0280	
Street: 2701 17th Street		Medicaid Provider Number: 18015	
City: Rock Island	State: Illinois	Zip: 61201	
Period Covered by Statement:	From: 01/01/2019	To: 12/31/2019	

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 checked="" type="checkbox"/> Other (Specify) Community	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

Type of Hospital

<input checked="" 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 checked="" 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)) Trinity Medical Center 18015 for the cost report beginning 01/01/2019 and ending 12/31/2019 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.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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
Part I-Hospital		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	182	66,430		26,366	39.69%		10,344	3.79
2.	Psych	54	19,710		9,194	46.65%		1,553	5.92
3.	Rehab	22	8,030		2,529	31.49%		176	14.37
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		4,828	66.14%			
6.	Coronary Care Unit	31	11,315		6,838	60.43%			
7.	NICU	9	3,285		1,151	35.04%			
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	20	7,300		1,894	25.95%			
22.	Total	338	123,370		52,800	42.80%		12,073	4.22
23.	Observation Bed Days				5,737				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				61			6	10.17
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	NICU								
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								
22.	Total				61	0.12%		6	10.17

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: 14-0280		Medicaid Provider Number: 18015	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2019 To: 12/31/2019	

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	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	19,616,933	95,238,453	0.205977				
2.	Recovery Room	4,022,650	9,785,780	0.411071				
3.	Delivery and Labor Room	3,585,392	5,574,937	0.643127				
4.	Anesthesiology	425,463	10,775,792	0.039483				
5.	Radiology - Diagnostic	5,072,517	27,617,473	0.183671	979		180	
6.	Radiology - Therapeutic	4,470,215	43,639,323	0.102435				
7.	Nuclear Medicine	1,434,185	3,427,526	0.418432				
8.	Laboratory	17,453,109	78,896,852	0.221214	10,176		2,251	
9.	Blood							
10.	Blood - Administration	1,342,481	2,728,509	0.492020				
11.	Intravenous Therapy	4,884,930	21,976,619	0.222279				
12.	Respiratory Therapy	2,814,712	19,070,623	0.147594	12,080		1,783	
13.	Physical Therapy	3,402,743	10,494,804	0.324231	32,496		10,536	
14.	Occupational Therapy	1,339,375	5,604,797	0.238969	35,362		8,450	
15.	Speech Pathology	553,494	1,600,876	0.345744	13,057		4,514	
16.	EKG							
17.	EEG	1,042,134	5,585,201	0.186588				
18.	Med. / Surg. Supplies	8,847,624	40,607,715	0.217880	224		49	
19.	Drugs Charged to Patients	26,370,422	95,064,791	0.277394	13,728		3,808	
20.	Renal Dialysis	1,009,787	2,071,682	0.487424	9,330		4,548	
21.	Ambulance							
22.	Gastrointestinal	1,052,291	3,928,468	0.267863				
23.	MRI	1,171,812	5,554,011	0.210985				
24.	Ultrasound	1,126,831	7,181,515	0.156907				
25.	Implantable Devices	29,358,104	61,923,617	0.474102				
26.	Cardiology	2,251,620	17,327,882	0.129942	354		46	
27.	Cardiopulmonary	1,625,986	8,954,540	0.181582	1,841		334	
28.	CT Scan	2,703,606	73,419,922	0.036824				
29.	Cardiac Rehab	1,532,631	3,899,698	0.393013				
30.	Cardiac Cath	7,291,163	92,915,773	0.078471				
31.	Hyperbaric Oxygen Therapy							
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	4,639,944	15,494,089	0.299465	78		23	
44.	Emergency	14,398,891	81,185,381	0.177358				
45.	Observation	4,910,757	6,390,817	0.768408				
46.	Total				129,705		36,522	

* 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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	27,469,586	7,867,033	2,509,284	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	32,103	9,194	2,529	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	855.67	855.67	992.20	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			61	
3.	Program general inpatient routine cost (Line 1c X Line 2)			60,524	
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)			60,524	

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	7,404,779	4,828	1,533.72		
9.	Coronary Care Unit	6,556,650	6,838	958.85		
10.	NICU	2,120,769	1,151	1,842.54		
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	1,549,915	1,894	818.33		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					36,522
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					97,046

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

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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.	NICU						
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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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	25,902	95,238,453	0.000272				
2.	Recovery Room	105	9,785,780	0.000011				
3.	Delivery and Labor Room	490,209	5,574,937	0.087931				
4.	Anesthesiology	1,366,121	10,775,792	0.126777				
5.	Radiology - Diagnostic	27,260	27,617,473	0.000987	979		1	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	109	78,896,852	0.000001	10,176			
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	68,390	21,976,619	0.003112				
12.	Respiratory Therapy	2,435	19,070,623	0.000128	12,080		2	
13.	Physical Therapy	63,281	10,494,804	0.006030	32,496		196	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG	68,525	5,585,201	0.012269				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	107,577	2,071,682	0.051927	9,330		484	
21.	Ambulance							
22.	Gastrointestinal	9,001	3,928,468	0.002291				
23.	MRI							
24.	Ultrasound	14,915	7,181,515	0.002077				
25.	Implantable Devices							
26.	Cardiology	324,066	17,327,882	0.018702	354		7	
27.	Cardiopulmonary	35,306	8,954,540	0.003943	1,841		7	
28.	CT Scan							
29.	Cardiac Rehab	4,324	3,899,698	0.001109				
30.	Cardiac Cath	1,332,350	92,915,773	0.014339				
31.	Hyperbaric Oxygen Therapy							
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	83,833	15,494,089	0.005411	78			
44.	Emergency	8,697,123	81,185,381	0.107127				
45.	Observation							
46.	Ancillary Total						697	

* 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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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	7,665,216	32,103	238.77				
48.	Psych	2,195,246	9,194	238.77				
49.	Rehab	77,745	2,529	30.74	61		1,875	
50.	Other (Sub)							
51.	Intensive Care Unit	2,140,480	4,828	443.35				
52.	Coronary Care Unit							
53.	NICU	582,874	1,151	506.41				
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						1,875	
68.	Ancillary Total (from line 46)						697	
69.	Total (Lines 67-68)						2,572	

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

Preliminary

Medicare Provider Number: 14-0280		Medicaid Provider Number: 18015	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2019 To: 12/31/2019	
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)	97,046	
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)	2,572	
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)	99,618	
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)	129,705	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	85,888	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. NICU		
	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		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	215,593	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		115,975
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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	99,618	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	99,618	
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)	99,618	

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.

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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)	115,975
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)
			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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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 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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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.	Gastrointestinal							
23.	MRI							
24.	Ultrasound							
25.	Implantable Devices							
26.	Cardiology							
27.	Cardiopulmonary							
28.	CT Scan							
29.	Cardiac Rehab							
30.	Cardiac Cath							
31.	Hyperbaric Oxygen Therapy							
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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

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.	NICU							
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: 14-0280	Medicaid Provider Number: 18015
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2019 To: 12/31/2019

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	61		61
Newborn Days			
Total Inpatient Revenue	215,593		215,593
Ancillary Revenue	129,705		129,705
Routine Revenue	85,888		85,888
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

- BHF Page 2 - Removed SNF data from Medicaid cost report
- BHF Page 3 - Total costs/total charges agree with as filed W/S C
- BHF Page 3 - Reclassified Blood costs and charges to Blood Administration. Blood is noncovered for Illinois Medicaid
- BHF Page 3 - Excluded Cardiac Rehab charges of \$6,636. Cardiac Rehab is noncovered for Illinois Medicaid
- BHF Pages 4 and 6 - Split Adults & Peds total costs and professional component between Psych and Acute based on patient days
(See attached spreadsheet for allocation)