

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: Union Hospital, Inc.		Medicare Provider Number: 15-0023	
Street: 1606 N. 7th Street		Medicaid Provider Number: 20003	
City: Terre Haute	State: IN	Zip: 47804	
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 checked="" 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 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)) Union Hospital, Inc. 20003 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: 15-0023	Medicaid Provider Number: 20003
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	203	74,095		46,780	63.14%		14,958	3.84
2.	Psych								
3.	Rehab	15	5,475		3,628	66.26%		256	14.17
4.	Other (Sub)								
5.	Intensive Care Unit	24	8,760		6,622	75.59%			
6.	Coronary Care Unit								
7.	Intensive Care-Nursery	15	5,475		4,095	74.79%			
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	30	10,950		3,149	28.76%			
22.	Total	287	104,755		64,274	61.36%		15,214	4.02
23.	Observation Bed Days				12,455				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych								
3.	Rehab				57			4	14.25
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Intensive Care-Nursery								
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				57	0.09%		4	14.25

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

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
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	20,988,528	190,838,459	0.109981				
2.	Recovery Room	3,151,540	10,326,790	0.305181				
3.	Delivery and Labor Room	7,602,187	23,267,054	0.326736				
4.	Anesthesiology							
5.	Radiology - Diagnostic	13,576,936	59,344,418	0.228782				
6.	Radiology - Therapeutic	7,891,480	49,242,021	0.160259				
7.	Nuclear Medicine	2,980,310	13,795,564	0.216034				
8.	Laboratory	10,503,437	85,445,848	0.122925				
9.	Blood							
10.	Blood - Administration	1,422,596	3,251,160	0.437566				
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,994,475	38,036,589	0.183888				
13.	Physical Therapy	4,359,012	13,481,876	0.323324				
14.	Occupational Therapy	2,314,893	9,459,694	0.244711				
15.	Speech Pathology	1,349,205	4,419,201	0.305305				
16.	EKG	15,838,789	90,663,580	0.174698				
17.	EEG	1,839,083	4,783,927	0.384430				
18.	Med. / Surg. Supplies	414,242	140,264	2.953302				
19.	Drugs Charged to Patients	59,259,703	303,742,255	0.195099				
20.	Renal Dialysis	1,881,594	3,551,182	0.529850				
21.	Ambulance							
22.	Cardiac Surgery	3,566,708	6,956,653	0.512705				
23.	WVSC	16,016,176	120,673,343	0.132723				
24.	OP Treatment Rm.	2,035,133	2,250,076	0.904473				
25.	Cat Scan	3,556,956	49,054,628	0.072510				
26.	MRI	2,538,855	14,146,782	0.179465				
27.	Cardiac Cath Lab	26,806,234	106,210,780	0.252387				
28.	O/P Psych Therapy	2,981,238	8,571,348	0.347814				
29.	Cardiac Rehab.	923,770	1,718,709	0.537479				
30.	Implant Devices	15,382,203	22,030,365	0.698227				
31.	Patient Nutrition	497,978	163,834	3.039528				
32.	Wound Clinic	2,134,833	8,538,740	0.250017				
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	336,158	729,832	0.460596				
44.	Emergency	14,524,707	139,882,508	0.103835				
45.	Observation	12,583,411	17,068,466	0.737232				
46.	Total							

* 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: 15-0023	Medicaid Provider Number: 20003
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)	59,845,998		3,016,577	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	59,235		3,628	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,010.31		831.47	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)			57	
3.	Program general inpatient routine cost (Line 1c X Line 2)			47,394	
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)			47,394	

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	11,917,694	6,622	1,799.71		
9.	Coronary Care Unit					
10.	Intensive Care-Nursery	4,188,329	4,095	1,022.79		
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	1,631,387	3,149	518.07		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					47,394

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

Preliminary

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
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.	Intensive Care-Nursery						
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: 15-0023	Medicaid Provider Number: 20003
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	2,658,832	190,838,459	0.013932				
2.	Recovery Room							
3.	Delivery and Labor Room	2,281,260	23,267,054	0.098047				
4.	Anesthesiology							
5.	Radiology - Diagnostic	476,766	59,344,418	0.008034				
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	9,960	90,663,580	0.000110				
17.	EEG	2,316,621	4,783,927	0.484251				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery	2,401,340	6,956,653	0.345186				
23.	WVSC	1,498,614	120,673,343	0.012419				
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab							
28.	O/P Psych Therapy							
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition							
32.	Wound Clinic							
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	3,912,523	139,882,508	0.027970				
45.	Observation							
46.	Ancillary Total							

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

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

Preliminary

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
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							
48.	Psych							
49.	Rehab	694,347	3,628	191.39	57		10,909	
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	904,000	4,095	220.76				
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)						10,909	
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)						10,909	

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

Preliminary

Medicare Provider Number: 15-0023		Medicaid Provider Number: 20003	
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)	47,394	
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)	10,909	
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)	58,303	
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)		
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych		
	C. Rehab	161,602	
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Intensive Care-Nursery		
	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)	161,602	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		103,299
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: 15-0023	Medicaid Provider Number: 20003
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)	58,303	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	58,303	
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)	58,303	

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: 15-0023	Medicaid Provider Number: 20003
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)	103,299
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: 15-0023	Medicaid Provider Number: 20003
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: 15-0023	Medicaid Provider Number: 20003
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	228,128	190,838,459	0.001195				
2.	Recovery Room							
3.	Delivery and Labor Room	435,153	23,267,054	0.018703				
4.	Anesthesiology							
5.	Radiology - Diagnostic	58,743	59,344,418	0.000990				
6.	Radiology - Therapeutic	45,055	49,242,021	0.000915				
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	30,797	38,036,589	0.000810				
13.	Physical Therapy	120,908	13,481,876	0.008968				
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	18,821	90,663,580	0.000208				
17.	EEG	3,422	4,783,927	0.000715				
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	9,695	303,742,255	0.000032				
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery							
23.	WVSC							
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	6,274	106,210,780	0.000059				
28.	O/P Psych Therapy							
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition							
32.	Wound Clinic	14,258	8,538,740	0.001670				
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	958,135	729,832	1.312816				
44.	Emergency	419,184	139,882,508	0.002997				
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: 15-0023	Medicaid Provider Number: 20003
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	1,687,000	59,235	28.48				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	59,884	4,095	14.62				
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: 15-0023	Medicaid Provider Number: 20003
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	57		57
Newborn Days			
Total Inpatient Revenue	161,602		161,602
Ancillary Revenue			
Routine Revenue	161,602		161,602
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Blood reclassified to Blood Administration

BHF Page 3 - Removed Cardiac Rehab Charges in the amount of \$1,010 since they are not covered by IL Medicaid.

BHF Page 3 - Adjusted total costs to as filed Medicare Report W/S C col 1

BHF Page 6a & 6b -adjusted to match as filed Medicare W/S A-8-2. Rehab amount is missing on provider cost report

BHF Supplement 2a & 2b - Adjusted Adults & Peds GME Cost to agree with as filed Medicare Report W/S B, Pt I, Col 25