

Hospital Statement of Cost

BHF Page 1

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

General Information Preliminary

Name of Hospital: Children's Hospital of Illinois		Medicare Provider Number: 14-0067
Street: 530 NE Glen Oak Avenue		Medicaid Provider Number: 16008
City: Peoria	State: Illinois	Zip: 61637-0001
Period Covered by Statement:	From: 10/01/2013	To: 09/30/2014

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)
☐ Church ☐	☐ Individual	☐ State ☐ Township
☐ Corporation	☐ Partnership	☐ City ☐ Hospital District
☐ Other (Specify)	☐ Corporation	☐ County ☐ Other (Specify)

Type of Hospital

☐ General Short-Term	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify) Children's Hospital

Health Care Program

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

☐ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐ DHS - Office of Rehabilitation Services
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐ U of I - Division of Specialized Care for Children

**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)) Children's Hospital of Illinois 16008 for the cost report beginning 10/01/2013 and ending 09/30/2014 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

BHF Page 2

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

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	68	24,820		20,622	83.09%		3,582	9.46
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	16	5,840		4,224	72.33%			
6.	Coronary Care Unit								
7.	Premature ICU	40	14,600		9,053	62.01%			
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	124	45,260		33,899	74.90%		3,582	9.46
23.	Observation Bed Days				1,470				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				11,911			3,566	5.64
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				1,408				
6.	Coronary Care Unit								
7.	Premature ICU				6,794				
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				20,113	59.33%		3,566	5.64

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

BHF Page 3

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)* (2)	Ratio of Cost to Charges (Col. 1 / 2) (3)	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.	Operating Room	49,469,603	246,646,089	0.200569	9,012,234		1,807,575	
2.	Recovery Room	4,786,225	38,732,971	0.123570	1,285,171		158,809	
3.	Delivery and Labor Room	8,860,410	16,996,933	0.521295	1,931		1,007	
4.	Anesthesiology	3,586,418	135,357,996	0.026496	5,249,818		139,099	
5.	Radiology - Diagnostic	44,513,287	304,914,438	0.145986	5,195,456		758,464	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	38,749,443	454,802,784	0.085201	16,932,620		1,442,676	
9.	Blood							
10.	Blood - Administration	8,107,041	16,826,961	0.481789	712,622		343,333	
11.	Intravenous Therapy	1,679,635	1,940,161	0.865719	6,858		5,937	
12.	Respiratory Therapy	10,520,195	117,350,738	0.089647	20,284,341		1,818,430	
13.	Physical Therapy	15,439,789	50,645,127	0.304862	500,253		152,508	
14.	Occupational Therapy							
15.	Speech Pathology	1,592,134	5,085,059	0.313100	433,194		135,633	
16.	EKG	4,731,816	63,925,018	0.074021	1,634,322		120,974	
17.	EEG	1,442,945	11,744,211	0.122864	1,105,678		135,848	
18.	Med. / Surg. Supplies	39,046,194	322,491,106	0.121077	15,584,527		1,886,928	
19.	Drugs Charged to Patients	47,737,649	392,723,693	0.121555	26,339,426		3,201,689	
20.	Renal Dialysis	2,712,114	9,437,381	0.287380	160,928		46,247	
21.	Ambulance	3,432,937	8,781,910	0.390910	791,700		309,483	
22.	CT Scan	6,870,389	144,633,812	0.047502	834,985		39,663	
23.	MRI	8,218,479	102,940,112	0.079837	1,267,417		101,187	
24.	Cardiac Catheterization	6,267,973	163,310,122	0.038381	317,393		12,182	
25.								
26.	Implantable Devices	41,882,966	181,673,105	0.230540	3,540,506		816,228	
27.	Digestive Diseases	6,243,384	77,422,672	0.080640	86,098		6,943	
28.	Enterostomal	467,821	1,049,953	0.445564	25,660		11,433	
29.	Diabetic Service	1,303,656	103,084	12.646541				
30.	Wound Care	1,620,326	6,437,452	0.251703				
31.	Psychology	1,732,611	3,203,288	0.540885	2,447		1,324	
32.	Neuro Diagnostic Ctr.	2,465,633	226,378	10.891664				
33.								
34.	Urological	121,983	822,946	0.148227	41,027		6,081	
35.	Sleep Disorders	4,613,862	14,359,728	0.321306				
36.	Pain Program	1,982,360	6,948,963	0.285274				
37.	Comp Epilepsy	2,517,188	435,399	5.781336				
38.	Cardiac Rehab	791,205	1,698,253	0.465893				
39.	Lithotripsy	263,150	3,189,953	0.082493	14,651		1,209	
40.	Kidney Acquisition	3,094,541	4,200,790	0.736657	162,430		119,655	
41.	Pancreas Acquisition	115,508	124,390	0.928596				
42.								
Outpatient Service Cost Centers								
43.	Clinic	8,103,174	3,821,105	2.120636	33,459		70,954	
44.	Emergency	33,325,640	93,427,534	0.356700	3,359,988		1,198,508	
45.	Observation	13,735,452	16,803,788	0.817402	192,980		157,742	
46.	Total				115,110,120		15,007,749	

* 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

BHF Page 4

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2013 To: 09/30/2014

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)	21,877,756			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	22,092			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	990.30			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	11,911			
3.	Program general inpatient routine cost (Line 1c X Line 2)	11,795,463			
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)	11,795,463			

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	8,688,468	4,224	2,056.93	1,408	2,896,157
9.	Coronary Care Unit					
10.	Premature ICU	17,737,055	9,053	1,959.25	6,794	13,311,145
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					15,007,749
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					43,010,514

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

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8) (3)	Average Cost Per Day (Col. 2 / Col. 3) (4)	Program Inpatient Days (BHF Page 2, Part II, Column 4) (5)	Program Inpatient Expenses (Col. 4 X Col. 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.	Premature ICU						
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) (1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2) (2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93) (3)	Ratio of Cost to Charges (Col. 2 / Col. 3) (4)	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

BHF Page 6(a)

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	31,432	135,357,996	0.000232	5,249,818		1,218	
5.	Radiology - Diagnostic	1,358,692	304,914,438	0.004456	5,195,456		23,151	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	1,037,913	454,802,784	0.002282	16,932,620		38,640	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy	9,196	1,940,161	0.004740	6,858		33	
12.	Respiratory Therapy	126,093	117,350,738	0.001074	20,284,341		21,785	
13.	Physical Therapy	775,212	50,645,127	0.015307	500,253		7,657	
14.	Occupational Therapy							
15.	Speech Pathology	1,400	5,085,059	0.000275	433,194		119	
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	280,016	392,723,693	0.000713	26,339,426		18,780	
20.	Renal Dialysis	5,200	9,437,381	0.000551	160,928		89	
21.	Ambulance	7,522	8,781,910	0.000857	791,700		678	
22.	CT Scan							
23.	MRI	4,591	102,940,112	0.000045	1,267,417		57	
24.	Cardiac Catherization							
25.								
26.	Implantable Devices							
27.	Digestive Diseases	34,807	77,422,672	0.000450	86,098		39	
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology	12,439	3,203,288	0.003883	2,447		10	
32.	Neuro Diagnostic Ctr.	780,841	226,378	3.449280				
33.								
34.	Urological							
35.	Sleep Disorders	887,803	14,359,728	0.061826				
36.	Pain Program	548,610	6,948,963	0.078948				
37.	Comp Epilepsy	1,096,028	435,399	2.517296				
38.	Cardiac Rehab	100,650	1,698,253	0.059267				
39.	Lithotripsy							
40.	Kidney Acquisition	72,000	4,200,790	0.017140	162,430		2,784	
41.	Pancreas Acquisition	8,000	124,390	0.064314				
42.								
	Outpatient Ancillary Cost Centers							
43.	Clinic	816,016	3,821,105	0.213555	33,459		7,145	
44.	Emergency	13,494,888	93,427,534	0.144442	3,359,988		485,323	
45.	Observation	93,302	16,803,788	0.005552	192,980		1,071	
46.	Ancillary Total						608,579	

* 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

BHF Page 6(b)

Preliminary

Medicare Provider Number:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

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	105,911	22,092	4.79	11,911		57,054	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	74,947	4,224	17.74	1,408		24,978	
52.	Coronary Care Unit							
53.	Premature ICU	127,457	9,053	14.08	6,794		95,660	
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)						177,692	
68.	Ancillary Total (from line 46)						608,579	
69.	Total (Lines 67-68)						786,271	

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0067		Medicaid Provider Number: 16008	
Program: Medicaid Hospital		Period Covered by Statement: From: 10/01/2013 To: 09/30/2014	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	43,010,514	
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)	786,271	
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)	3,698,753	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	47,495,538	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	115,110,120	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	41,292,230	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	8,004,032	
	F. Coronary Care Unit		
	G. Premature ICU		
	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)	164,406,382	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		116,910,844
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

BHF Page 8

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2013 To: 09/30/2014

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)	47,495,538	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	47,495,538	
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)	47,495,538	

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

BHF Page 9

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2013 To: 09/30/2014

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)	116,910,844
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period	Sum of Columns 1 - 4
		to	to	to		
		(1)	(2)	(3)	(4)	(5)
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	Total (Sum of Lines 1 - 3)					

**Hospital Statement of Cost
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2013 To: 09/30/2014

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

1. Gross Routine Revenues	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
(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:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

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	5,434,000	246,646,089	0.022032	9,012,234		198,558	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	461,695	135,357,996	0.003411	5,249,818		17,907	
5.	Radiology - Diagnostic	5,530,536	304,914,438	0.018138	5,195,456		94,235	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	32,179	454,802,784	0.000071	16,932,620		1,202	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,241,677	63,925,018	0.019424	1,634,322		31,745	
17.	EEG	139,907	11,744,211	0.011913	1,105,678		13,172	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Catherization	233,645	163,310,122	0.001431	317,393		454	
25.								
26.	Implantable Devices							
27.	Digestive Diseases							
28.	Enterostomal							
29.	Diabetic Service							
30.	Wound Care							
31.	Psychology							
32.	Neuro Diagnostic Ctr.							
33.								
34.	Urological							
35.	Sleep Disorders							
36.	Pain Program							
37.	Comp Epilepsy							
38.	Cardiac Rehab							
39.	Lithotripsy							
40.	Kidney Acquisition							
41.	Pancreas Acquisition							
42.								
	Outpatient Ancillary Centers							
43.	Clinic	866,726	3,821,105	0.226826	33,459		7,589	
44.	Emergency	7,722,884	93,427,534	0.082662	3,359,988		277,743	
45.	Observation							
46.	Ancillary Total						642,605	

* 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:	14-0067	Medicaid Provider Number:	16008
Program:	Medicaid Hospital	Period Covered by Statement:	From: 10/01/2013 To: 09/30/2014

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	3,222,466	22,092	145.87	11,911		1,737,458	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	996,381	4,224	235.89	1,408		332,133	
52.	Coronary Care Unit							
53.	Premature ICU	1,314,604	9,053	145.21	6,794		986,557	
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)						3,056,148	
68.	Ancillary Total (from line 46)						642,605	
69.	Total (Lines 67-68)						3,698,753	

Preliminary

Medicare Provider Number: 14-0067	Medicaid Provider Number: 16008
Program: Medicaid Hospital	Period Covered by Statement: From: 10/01/2013 To: 09/30/2014

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	20,113		20,113
Newborn Days			
Total Inpatient Revenue	164,406,687	(305)	164,406,382
Ancillary Revenue	115,110,425	(305)	115,110,120
Routine Revenue	49,296,262		49,296,262
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Total costs & Charges agree with as filed W/S C Part 1, cols. 1 and 8.

BHF Page 3 - Clinic costs & charges include all Clinic data, W/S C lines 90.01-90.07.

BHF Page 3- Removed Cardiac Rehab charges of \$305 as this is non-covered by Illinois Medicaid.

BHF Supp No. 2(a)- Removed amounts from Col. 1 for Cardiac Rehab and Lithotripsy as not supported by W/S B, Col. 25. Part I,

Spread Adults & Peds and ICU costs between Acute and Children's Hospitals.