

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: 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: 01/01/2017	To: 12/31/2017	

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)

Health Care Program

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

☒ Medicaid Hospital	☐ Medicaid Sub II Rehab	☐
☐ Medicaid Sub I Psych	☐ Medicaid Sub III Other	☐

NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) Union Hospital, Inc. 20003 for the cost report beginning 01/01/2017 and ending 12/31/2017 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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

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		49,041	73.82%		16,055	3.72
2.	Psych								
3.	Rehab	22	8,030		3,432	42.74%		276	12.43
4.	Other (Sub)								
5.	Intensive Care Unit	36	13,140		7,320	55.71%			
6.	Coronary Care Unit								
7.	Intensive Care-Nursery	15	5,475		3,441	62.85%			
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		3,497	31.94%			
22.	Total	285	104,025		66,731	64.15%		16,331	3.87
23.	Observation Bed Days				9,706				

Part II-Program		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				923			420	3.01
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				172				
6.	Coronary Care Unit								
7.	Intensive Care-Nursery				169				
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				120				
22.	Total				1,384	2.07%		420	3.01

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:		Medicaid Provider Number:	
15-0023		20003	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2017	To: 12/31/2017

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	19,442,185	169,133,599	0.114952	1,946,197		223,719	
2.	Recovery Room	3,326,046	8,039,090	0.413734	33,428		13,830	
3.	Delivery and Labor Room	7,520,716	22,289,184	0.337415	714,596		241,115	
4.	Anesthesiology							
5.	Radiology - Diagnostic	13,188,135	52,629,930	0.250582	185,149		46,395	
6.	Radiology - Therapeutic	7,783,930	38,886,606	0.200170	51,596		10,328	
7.	Nuclear Medicine	1,950,152	8,071,387	0.241613	12,646		3,055	
8.	Laboratory	10,977,816	96,433,889	0.113838	771,319		87,805	
9.	Blood							
10.	Blood - Administration	1,376,416	3,148,106	0.437220	47,802		20,900	
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,156,342	18,394,656	0.334681	203,529		68,117	
13.	Physical Therapy	3,888,879	11,958,997	0.325184	66,890		21,752	
14.	Occupational Therapy	2,035,616	8,547,786	0.238145	65,173		15,521	
15.	Speech Pathology	1,020,571	3,227,110	0.316249	10,519		3,327	
16.	EKG	5,623,886	31,444,614	0.178851	152,884		27,343	
17.	EEG	1,755,000	4,692,335	0.374014	26,340		9,852	
18.	Med. / Surg. Supplies	1,569,842	802,001	1.957407	52,938		103,621	
19.	Drugs Charged to Patients	56,080,890	261,571,943	0.214399	1,281,769		274,810	
20.	Renal Dialysis	2,008,225	3,783,243	0.530821	13,122		6,965	
21.	Ambulance							
22.	Cardiac Surgery	3,800,794	6,994,247	0.543417	205,878		111,878	
23.	WVSC	14,336,428	100,498,844	0.142653	19,991		2,852	
24.	OP Treatment Rm.	5,365,741	2,795,186	1.919636	19,638		37,698	
25.	Cat Scan	3,924,226	66,810,076	0.058737	223,514		13,129	
26.	MRI	2,736,851	15,831,773	0.172871	37,888		6,550	
27.	Cardiac Cath Lab	19,325,921	101,602,797	0.190211	410,318		78,047	
28.	O/P Psych Therapy	2,381,244	6,836,654	0.348305				
29.	Cardiac Rehab.	911,372	1,283,545	0.710043				
30.	Implant Devices	13,594,751	15,433,507	0.880859				
31.	Patient Nutrition	637,605	197,862	3.222473				
32.	Wound Clinic	1,807,090	6,783,717	0.266386				
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	332,384	692,316	0.480104				
44.	Emergency	18,950,084	132,553,056	0.142962	427,158		61,067	
45.	Observation	10,476,948	13,711,191	0.764117				
46.	Total				6,980,282		1,489,676	

* 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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	63,413,267		3,181,488	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	58,747		3,432	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,079.43		927.01	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	923			
3.	Program general inpatient routine cost (Line 1c X Line 2)	996,314			
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)	996,314			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. D) (E)
8.	Intensive Care Unit	12,639,435	7,320	1,726.70	172	296,992
9.	Coronary Care Unit					
10.	Intensive Care-Nursery	4,047,848	3,441	1,176.36	169	198,805
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	2,127,591	3,497	608.40	120	73,008
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,489,676
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					3,054,795

**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: 01/01/2017 To: 12/31/2017

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)	
		(1)	(2)	(3)	(4)	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:		Medicaid Provider Number:	
15-0023		20003	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2017	To: 12/31/2017

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	2,044,250	169,133,599	0.012087	1,946,197		23,524	
2.	Recovery Room							
3.	Delivery and Labor Room	2,063,490	22,289,184	0.092578	714,596		66,156	
4.	Anesthesiology							
5.	Radiology - Diagnostic	635,264	52,629,930	0.012070	185,149		2,235	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine	10,850	8,071,387	0.001344	12,646		17	
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	84,510	31,444,614	0.002688	152,884		411	
17.	EEG	2,210,900	4,692,335	0.471173	26,340		12,411	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	493,283	261,571,943	0.001886	1,281,769		2,417	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery	2,505,153	6,994,247	0.358173	205,878		73,740	
23.	WVSC	1,182,650	100,498,844	0.011768	19,991		235	
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	1,846,966	101,602,797	0.018178	410,318		7,459	
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	1,024,736	132,553,056	0.007731	427,158		3,302	
45.	Observation							
46.	Ancillary Total						191,907	

* 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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2017 To: 12/31/2017

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	Routine Service Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	548,000	3,441	159.26	169		26,915	
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)						26,915	
68.	Ancillary Total (from line 46)						191,907	
69.	Total (Lines 67-68)						218,822	

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

BHF Page 7

Preliminary

Medicare Provider Number: 15-0023		Medicaid Provider Number: 20003	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2017 To: 12/31/2017	
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)	3,054,795	
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)	218,822	
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)	51,829	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	3,325,446	
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)	6,980,282	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,651,191	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	542,508	
	F. Coronary Care Unit		
	G. Intensive Care-Nursery	713,409	
	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	164,420	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	10,051,810	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,726,364
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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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)	3,325,446	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	3,325,446	
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)	3,325,446	

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:	Medicaid Provider Number:
15-0023	20003
Program:	Period Covered by Statement:
Medicaid Hospital	From: 01/01/2017 To: 12/31/2017

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)	6,726,364
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)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A)	Ratio	Amount (Col. 1x3A)
			(1)	(2A)	(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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

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: 01/01/2017 To: 12/31/2017

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	212,347	169,133,599	0.001255	1,946,197		2,442	
2.	Recovery Room							
3.	Delivery and Labor Room	483,952	22,289,184	0.021712	714,596		15,515	
4.	Anesthesiology							
5.	Radiology - Diagnostic	74,075	52,629,930	0.001407	185,149		261	
6.	Radiology - Therapeutic	34,568	38,886,606	0.000889	51,596		46	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	74,075	18,394,656	0.004027	203,529		820	
13.	Physical Therapy	4,938	11,958,997	0.000413	66,890		28	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,938	31,444,614	0.000157	152,884		24	
17.	EEG	14,815	4,692,335	0.003157	26,340		83	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	69,136	261,571,943	0.000264	1,281,769		338	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery							
23.	WVSC							
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	24,691	101,602,797	0.000243	410,318		100	
28.	O/P Psych Therapy	158,025	6,836,654	0.023114				
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition	9,877	197,862	0.049919				
32.	Wound Clinic	83,950	6,783,717	0.012375				
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	770,373	692,316	1.112748				
44.	Emergency	518,520	132,553,056	0.003912	427,158		1,671	
45.	Observation							
46.	Ancillary Total						21,328	

* 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:		Medicaid Provider Number:	
15-0023		20003	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2017	To: 12/31/2017

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	1,802,476	58,747	30.68	923		28,318	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	44,445	3,441	12.92	169		2,183	
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)						30,501	
68.	Ancillary Total (from line 46)						21,328	
69.	Total (Lines 67-68)						51,829	

Preliminary

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2017 To: 12/31/2017

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,095	169	1,264
Newborn Days	120		120
Total Inpatient Revenue	10,055,179	(3,369)	10,051,810
Ancillary Revenue	6,983,651	(3,369)	6,980,282
Routine Revenue	3,071,528		3,071,528
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3, Clinic costs and charges include Patient Nutrition (90.05) and Wound Clinic (90.07) from W/S C.

BHF Page 3 - Removed Cardiac Rehab Charges in the amount of \$3,369 since they are not covered by IL Medicaid.