

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: Massac Memorial Hospital	Medicare Provider Number: 14-1323	
Street: 28 Chick Street, PO Box 850	Medicaid Provider Number: 13019	
City: Metropolis	State: Illinois	Zip: 62960
Period Covered by Statement:	From: 04/01/2019	To: 03/31/2020

Type of Control

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

Type of Hospital

☐ XXXX XXXX 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)

☐ XXXX XXXX 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)) Massac Memorial Hospital 13019 for the cost report beginning 04/01/2019 and ending 03/31/2020 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:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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	25	9,150		1,944	21.25%		510	3.81
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total	25	9,150		1,944	21.25%		510	3.81
23.	Observation Bed Days				311				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				203			53	3.83
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	Total				203	10.44%		53	3.83

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:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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	1,162,896	2,185,672	0.532054				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	313,024	456,348	0.685933		72,662		49,841
5.	Radiology - Diagnostic	2,158,979	17,858,713	0.120892	155,154	5,383,925	18,757	650,873
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,416,697	6,688,110	0.361342	84,746	1,983,234	30,622	716,626
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	777,116	1,442,116	0.538872		133,582		71,984
13.	Physical Therapy	1,248,824	1,679,728	0.743468	2,711	437,186	2,016	325,034
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	501,802	2,884,301	0.173977	84,529	535,950	14,706	93,243
17.	EEG							
18.	Med. / Surg. Supplies	272,833	64,366	4.238775	100	25,238	424	106,978
19.	Drugs Charged to Patients	1,521,839	2,337,631	0.651018	62,564	228,932	40,730	149,039
20.	Renal Dialysis							
21.	Ambulance	952,319	2,268,795	0.419747		499,752		209,769
22.	Implants Chgd	19,919	23,563	0.845351				
23.	Geri Psych	743,745	909,113	0.818100				
24.	Wound Care	197,996	174,292	1.136002		49,587		56,331
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
Outpatient Service Cost Centers								
43.	Clinic	165,174	70,929	2.328723				
44.	Emergency	3,459,799	5,336,624	0.648312	51,473	2,163,083	33,371	1,402,353
45.	Observation	546,918	195,895	2.791894		90,474		252,594
46.	Total				441,277	11,603,605	140,626	4,084,665

* 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: 14-1323	Medicaid Provider Number: 13019
Program: Medicaid Hospital	Period Covered by Statement: From: 04/01/2019 To: 03/31/2020

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)	3,965,604			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	2,255			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,758.58			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	203			
3.	Program general inpatient routine cost (Line 1c X Line 2)	356,992			
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)	356,992			

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					
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					140,626
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					497,618

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

Preliminary

Medicare Provider Number:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
		(1)	(2)	(3)	(4)	Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(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:	
14-1323		13019	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 04/01/2019	To: 03/31/2020

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							
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	151,753	2,884,301	0.052613	84,529	535,950	4,447	28,198
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Implants Chgd							
23.	Geri Psych							
24.	Wound Care							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total						4,447	28,198

* 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:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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	335,921	2,255	148.97	203		30,241	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)						30,241	
68.	Ancillary Total (from line 46)						4,447	28,198
69.	Total (Lines 67-68)						34,688	28,198

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-1323	Medicaid Provider Number: 13019
Program: Medicaid Hospital	Period Covered by Statement: From: 04/01/2019 To: 03/31/2020

Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		4,084,665
2.	Inpatient Operating Services (BHF Page 4, Line 25)	497,618	
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)	34,688	28,198
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)	532,306	4,112,863
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	11.00%	89.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	441,277	11,603,605
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	144,245	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	585,522	11,603,605
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		7,543,958
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: 14-1323	Medicaid Provider Number: 13019
Program: Medicaid Hospital	Period Covered by Statement: From: 04/01/2019 To: 03/31/2020

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)	532,306	4,112,863
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	532,306	4,112,863
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)	532,306	4,112,863

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:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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)	7,543,958
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)	(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: 14-1323	Medicaid Provider Number: 13019
Program: Medicaid Hospital	Period Covered by Statement: From: 04/01/2019 To: 03/31/2020

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:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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.	Implants Chgd							
23.	Geri Psych							
24.	Wound Care							
25.	Other							
26.	Other							
27.	Other							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	Ancillary Total							

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number:	14-1323	Medicaid Provider Number:	13019
Program:	Medicaid Hospital	Period Covered by Statement:	From: 04/01/2019 To: 03/31/2020

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.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 14-1323	Medicaid Provider Number: 13019
Program: Medicaid Hospital	Period Covered by Statement: From: 04/01/2019 To: 03/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	203		203
Newborn Days			
Total Inpatient Revenue	585,522		585,522
Ancillary Revenue	441,277		441,277
Routine Revenue	144,245		144,245
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue	12,169,107	(565,502)	11,603,605
Outpatient Received and Receivable			

Notes:

Removed \$565,502 in Rural Health Clinic O/P charges from BHF Page 3 as these are covered separate from the hospital by IL Medicaid