

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: Crawford Memorial Hospital		Medicare Provider Number: 14-1343	
Street: 1000 North Allen Street		Medicaid Provider Number: 18014	
City: Robinson	State: Illinois	Zip: 62454	
Period Covered by Statement:	From: 05/01/2019	To: 04/30/2020	

Type of Control

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

Type of Hospital

☐ XXXX General Short-Term XXXX	☐ Psychiatric	☐ Cancer
☐ General Long-Term	☐ Rehabilitation	☐ Other (Specify) _____

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

☐ XXXX Medicaid Hospital XXXX	☐ 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)) Crawford Memorial Hospital 18014 for the cost report beginning 05/01/2019 and ending 04/30/2020 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:	14-1343	Medicaid Provider Number:	18014
Program:	Medicaid Hospital	Period Covered by Statement:	From: 05/01/2019 To: 04/30/2020

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	9,125		2,075	22.74%		1,046	1.98
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	10	3,650		281	7.70%			
22.	Total	35	12,775		2,356	18.44%		1,046	1.98
23.	Observation Bed Days				385				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				36			24	1.50
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				67				
22.	Total				103	4.37%		24	1.50

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 Prog BHF Page 3

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-1343	18014
Program:	Period Covered by Statement:
Medicaid Hospital	From: 05/01/2019 To: 04/30/2020

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-1) W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-1) 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 (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	4,611,324	13,488,137	0.341880	156,470	338,688	53,494	115,791
2.	Recovery Room							
3.	Delivery and Labor Room	315,941	915,087	0.345258	34,648		11,962	
4.	Anesthesiology							
5.	Radiology - Diagnostic	3,256,870	15,452,777	0.210763	184,735	399,868	38,935	84,277
6.	Radiology - Therapeutic	455,439	2,691,549	0.169211	32,050	69,375	5,423	11,739
7.	Nuclear Medicine							
8.	Laboratory	3,077,956	14,163,897	0.217310	141,900	307,152	30,836	66,747
9.	Blood							
10.	Blood - Administration	235,218	544,308	0.432141	4,188	9,066	1,810	3,918
11.	Intravenous Therapy							
12.	Respiratory Therapy	1,036,000	1,471,918	0.703844	4,479	9,695	3,153	6,824
13.	Physical Therapy	2,559,533	4,010,526	0.638204	60,572	131,113	38,657	83,677
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	72,720	691,935	0.105097	17,156	37,135	1,803	3,903
17.	EEG							
18.	Med. / Surg. Supplies	794,038	1,141,855	0.695393	8,013	17,346	5,572	12,062
19.	Drugs Charged to Patients	4,539,842	7,743,221	0.586299	129,639	280,611	76,007	164,522
20.	Renal Dialysis							
21.	Ambulance							
22.	Implant Devices Charged	410,529	479,623	0.855941	1,182	2,557	1,012	2,189
23.	Cardiac Rehab	157,049	253,500	0.619523				
24.	Other							
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	2,179,571	2,480,654	0.878628	5,817	12,591	5,111	11,063
44.	Emergency	3,087,926	7,039,697	0.438645	115,912	250,899	50,844	110,056
45.	Observation	565,935	610,592	0.926863	7,664	16,590	7,103	15,377
46.	Total				904,425	1,882,686	331,722	692,145

* 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: 14-1343	Medicaid Provider Number: 18014
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2019 To: 04/30/2020

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)	4,977,068			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	2,460			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,023.20			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	36			
3.	Program general inpatient routine cost (Line 1c X Line 2)	72,835			
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)	72,835			

Line No.	Description	Total Dept. Costs (CMS 2552-10, 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	156,952	281	558.55	67	37,423
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					331,722
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					441,980

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

Preliminary

Medicare Provider Number:	14-1343	Medicaid Provider Number:	18014
Program:	Medicaid Hospital	Period Covered by Statement:	From: 05/01/2019 To: 04/30/2020

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 (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:
14-1343	18014
Program:	Period Covered by Statement:
Medicaid Hospital	From: 05/01/2019 To: 04/30/2020

Line No.	Cost Centers	Professional Component (CMS 2552-16 W/S A-8-2, Col. 4)	Total Dept. Charges CMS 2552-16 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	819,314	13,488,137	0.060743	156,470	338,688	9,504	20,573
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	338,420	15,452,777	0.021900	184,735	399,868	4,046	8,757
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	27,160	1,471,918	0.018452	4,479	9,695	83	179
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.	Implant Devices Charged							
23.	Cardiac Rehab							
24.	Other							
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	2,784,844	2,480,654	1.122625	5,817	12,591	6,530	14,135
44.	Emergency	1,342,786	7,039,697	0.190745	115,912	250,899	22,110	47,858
45.	Observation							
46.	Ancillary Total						42,273	91,502

* 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:	Medicaid Provider Number:
14-1343	18014
Program:	Period Covered by Statement:
Medicaid Hospital	From: 05/01/2019 To: 04/30/2020

Line No.	Cost Centers	Professional Component (CMS 2552-16 W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-16 W/S S-3 Pt. 1, Col. 8)	Professional Component Cost (Col. 1 / Per Diem 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	1,115,989	2,460	453.65	36		16,331	
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	9,500	281	33.81	67		2,265	
67.	Routine Total (lines 47-66)						18,596	
68.	Ancillary Total (from line 46)						42,273	91,502
69.	Total (Lines 67-68)						60,869	91,502

Hospital Statement of Cost

BHF Page 7

Computation of Lesser of Reasonable Cost or Customary Charges

Preliminary

Medicare Provider Number: 14-1343		Medicaid Provider Number: 18014	
Program: Medicaid Hospital		Period Covered by Statement: From: 05/01/2019 To: 04/30/2020	
Line No.	Reasonable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		692,145
2.	Inpatient Operating Services (BHF Page 4, Line 25)	441,980	
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)	60,869	91,502
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)	502,849	783,647
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	39.00%	61.00%

Line No.	Customary Charges	Program Inpatient (1)	Program Outpatient (2)
9.	Ancillary Services (See Instructions)	904,425	1,882,686
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	54,969	
	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	126,439	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	1,085,833	1,882,686
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,682,023
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: 14-1343	Medicaid Provider Number: 18014
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2019 To: 04/30/2020

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)	502,849	783,647
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	502,849	783,647
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)	502,849	783,647

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: 14-1343	Medicaid Provider Number: 18014
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2019 To: 04/30/2020

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)	1,682,023
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

BHF Supplement No. 1

Teaching Physicians / Routine Services Questionnaire

Preliminary

Medicare Provider Number: 14-1343	Medicaid Provider Number: 18014
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2019 To: 04/30/2020

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

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 29)				
(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 3)				
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 1)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-1343	18014
Program:	Period Covered by Statement:
Medicaid Hospital	From: 05/01/2019 To: 04/30/2020

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.	Implant Devices Charged							
23.	Cardiac Rehab							
24.	Other							
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:	14-1343	Medicaid Provider Number:	18014
Program:	Medicaid Hospital	Period Covered by Statement:	From: 05/01/2019 To: 04/30/2020

Line No.	Cost Centers	G M E Cost (CMS 2552-16 W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-16 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)							

Preliminary

Medicare Provider Number: 14-1343	Medicaid Provider Number: 18014
Program: Medicaid Hospital	Period Covered by Statement: From: 05/01/2019 To: 04/30/2020

	Provider's		Audited
Inpatient Reconciliation	Records	Adjustments	Cost Report
Adult Days	36		36
Newborn Days	67		67
Total Inpatient Revenue	1,085,833		1,085,833
Ancillary Revenue	904,425		904,425
Routine Revenue	181,408		181,408
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue	1,882,686		1,882,686
Outpatient Received and Receivable			

Notes:

BHF Page 2, Pt 1, line 23 - Adjusted Observation inpatient days to tie to Medicare S-3 col 8 line 28

BHF Page 2, Pt 1, line 21 - Adjusted Newborn Nursery Inpatient Days to agree to Medicare S-3, Col 8, line 13

BHF Page 2, Pt 21, line 21 - Newborn Nursery Medicaid Days total 67 is same as prior year.

BHF Page 4 - Adjusted line 1b to agree with W/S D-1, Part 1 line 2

BHF Page 3 - Removed RHC Costs/Charges from line 43, column 1 & 2 since they are not covered by IL Medicaid.

BHF Page 3 - Removed Cardiac Rehab IP & OP Charges from line 23, column 4 & 5 since they are not covered by IL Medicaid.

BHF Page 3 - Moved Blood to Blood Admin

BHF Page 3 - Combined Pain Management Clinic with Clinic

BHF Page 3 - Removed I/P & O/P RHC Costs/Charges since they are not covered by IL Medicaid.

BHF Page 7 - Adjusted routine charges to avg per Medicare report as charges appear understated

A&P (3,756,202/(2,075+385))x36 Medicaid Days = 54,969

Nurs (530,287/281)x67 Medicaid Days = 126,439