

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: 01/01/2020	To: 12/31/2020

Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
☐ Church	☐ Individual	☐ State	☐ Township
☐ XXXX Corporation XXXX	☐ Partnership	☐ City	☐ Hospital District
☐ 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)) Union Hospital, Inc. 20003 for the cost report beginning 01/01/2020 and ending 12/31/2020 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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	203	74,298		47,467	63.89%		14,593	4.05
2.	Psych								
3.	Rehab	15	5,490		4,176	76.07%		307	13.60
4.	Other (Sub)								
5.	Intensive Care Unit	24	8,784		7,699	87.65%			
6.	Coronary Care Unit								
7.	Intensive Care-Nursery	15	5,490		3,916	71.33%			
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	10,980		2,894	26.36%			
22.	Total	287	105,042		66,152	62.98%		14,900	4.25
23.	Observation Bed Days				9,789				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				731			355	3.10
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				234				
6.	Coronary Care Unit								
7.	Intensive Care-Nursery				136				
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				21				
22.	Total				1,122	1.70%		355	3.10

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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	22,316,864	179,118,614	0.124593	1,442,195		179,687	
2.	Recovery Room	3,104,404	8,797,944	0.352856	52,791		18,628	
3.	Delivery and Labor Room	7,655,343	22,087,728	0.346588	308,120		106,791	
4.	Anesthesiology							
5.	Radiology - Diagnostic	13,922,557	58,427,803	0.238287	261,639		62,345	
6.	Radiology - Therapeutic	8,663,599	46,434,749	0.186576	39,790		7,424	
7.	Nuclear Medicine	2,927,351	8,759,344	0.334198	19,707		6,586	
8.	Laboratory	11,018,653	86,151,024	0.127899	817,932		104,613	
9.	Blood							
10.	Blood - Administration	1,423,703	3,142,730	0.453015	42,226		19,129	
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,214,407	36,650,788	0.196842	568,352		111,876	
13.	Physical Therapy	4,152,341	12,516,599	0.331747	143,160		47,493	
14.	Occupational Therapy	2,469,850	9,904,420	0.249368	101,118		25,216	
15.	Speech Pathology	1,295,635	4,094,040	0.316469	22,931		7,257	
16.	EKG	14,734,284	79,104,830	0.186263	264,169		49,205	
17.	EEG	2,181,547	3,179,436	0.686143	20,509		14,072	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	59,902,239	308,831,438	0.193964	807,027		156,534	
20.	Renal Dialysis	2,224,545	3,943,015	0.564174	60,786		34,294	
21.	Ambulance							
22.	Cardiac Surgery	3,535,371	5,853,080	0.604019	98,598		59,555	
23.	WVSC	16,409,415	113,042,295	0.145162	1,013		147	
24.	OP Treatment Rm.	1,985,241	2,257,663	0.879335	412		362	
25.	Cat Scan	3,421,799	48,341,336	0.070784	249,931		17,691	
26.	MRI	2,934,894	13,569,668	0.216283	43,258		9,356	
27.	Cardiac Cath Lab	35,113,028	97,492,408	0.360162	644,707		232,199	
28.	O/P Psych Therapy	2,714,184	7,099,331	0.382315				
29.	Cardiac Rehab.	889,143	1,407,197	0.631854				
30.	Implant Devices	13,452,233	23,297,178	0.577419	140,833		81,320	
31.	Patient Nutrition	556,933	139,805	3.983642				
32.	Wound Clinic	2,432,289	10,186,728	0.238770	338		81	
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	405,078	788,290	0.513869	6		3	
44.	Emergency	14,197,910	124,540,349	0.114002	532,720		60,731	
45.	Observation	9,350,844	13,507,787	0.692256	51,399		35,581	
46.	Total				6,735,667		1,448,176	

* 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: 01/01/2020 To: 12/31/2020

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)	54,693,328		3,254,455	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	57,256		4,176	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	955.24		779.32	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	731			
3.	Program general inpatient routine cost (Line 1c X Line 2)	698,280			
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)	698,280			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	11,714,065	7,699	1,521.50	234	356,031
9.	Coronary Care Unit					
10.	Intensive Care-Nursery	4,368,444	3,916	1,115.54	136	151,713
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,641,693	2,894	567.27	21	11,913
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					1,448,176
25.	Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)					2,666,113

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: 01/01/2020 To: 12/31/2020

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.	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	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:	
15-0023		20003	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2020	To: 12/31/2020

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	2,792,100	179,118,614	0.015588	1,442,195		22,481	
2.	Recovery Room							
3.	Delivery and Labor Room	2,367,590	22,087,728	0.107190	308,120		33,027	
4.	Anesthesiology							
5.	Radiology - Diagnostic	228,788	58,427,803	0.003916	261,639		1,025	
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	2,320	79,104,830	0.000029	264,169		8	
17.	EEG	2,797,649	3,179,436	0.879920	20,509		18,046	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery	2,200,051	5,853,080	0.375879	98,598		37,061	
23.	WVSC	1,569,530	113,042,295	0.013884	1,013		14	
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab							
28.	O/P Psych Therapy							
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition							
32.	Wound Clinic							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
44.	Emergency	3,678,468	124,540,349	0.029536	532,720		15,734	
45.	Observation							
46.	Ancillary Total						127,396	

* 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: 01/01/2020 To: 12/31/2020

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							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	904,000	3,916	230.85	136		31,396	
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)						31,396	
68.	Ancillary Total (from line 46)						127,396	
69.	Total (Lines 67-68)						158,792	

**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: 01/01/2020 To: 12/31/2020

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)	2,666,113	
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)	158,792	
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)	41,072	
7.	Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)	2,865,977	
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)	6,735,667	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	1,656,410	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	529,493	
	F. Coronary Care Unit		
	G. Intensive Care-Nursery	308,959	
	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	48,342	
11.	Services of Teaching Physicians (Provider's Records)		
12.	Total Charges for Patient Services (Sum of Lines 9 through 11)	9,278,871	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		6,412,894
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: 01/01/2020 To: 12/31/2020

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)	2,865,977	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	2,865,977	
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)	2,865,977	

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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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)	6,412,894
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: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

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:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	240,660	179,118,614	0.001344	1,442,195		1,938	
2.	Recovery Room							
3.	Delivery and Labor Room	467,744	22,087,728	0.021177	308,120		6,525	
4.	Anesthesiology							
5.	Radiology - Diagnostic	32,088	58,427,803	0.000549	261,639		144	
6.	Radiology - Therapeutic	22,831	46,434,749	0.000492	39,790		20	
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	13,576	36,650,788	0.000370	568,352		210	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients	27,769	308,831,438	0.000090	807,027		73	
20.	Renal Dialysis							
21.	Ambulance							
22.	Cardiac Surgery							
23.	WVSC							
24.	OP Treatment Rm.							
25.	Cat Scan							
26.	MRI							
27.	Cardiac Cath Lab	23,449	97,492,408	0.000241	644,707		155	
28.	O/P Psych Therapy	115,394	7,099,331	0.016254				
29.	Cardiac Rehab.							
30.	Implant Devices							
31.	Patient Nutrition							
32.	Wound Clinic	49,983	10,186,728	0.004907	338		2	
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	779,985	788,290	0.989465	6		6	
44.	Emergency	432,571	124,540,349	0.003473	532,720		1,850	
45.	Observation							
46.	Ancillary Total						10,923	

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

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number:	15-0023	Medicaid Provider Number:	20003
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2020 To: 12/31/2020

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	2,171,494	57,256	37.93	731		27,727	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Intensive Care-Nursery	69,730	3,916	17.81	136		2,422	
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)						30,149	
68.	Ancillary Total (from line 46)						10,923	
69.	Total (Lines 67-68)						41,072	

Hospital Statement of Cost Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number: 15-0023	Medicaid Provider Number: 20003
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2020 To: 12/31/2020

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,101		1,101
Newborn Days	21		21
Total Inpatient Revenue	9,280,560	(1,689)	9,278,871
Ancillary Revenue	6,737,356	(1,689)	6,735,667
Routine Revenue	2,543,204		2,543,204
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

BHF Page 3 - Blood reclassified to Blood Administration

BHF Page 3 - Removed Cardiac Rehab Charges in the amount of \$1,689 since they are not covered by IL Medicaid.

BHF Page 3 - Reclassified Med/Surg Supplies costs to Operating Room costs

BHF Page 6a & 6b -Rehab amount is missing on provider cost report; left off as provider did not claim on either rehab or XIX cost report

BHF Page 2 - Added the Rehab information to Part I to agree with the Medicare Report

BHF Page 2 - Changed the hospital discharge days to agree with the Medicare Report

BHF Page 3 - I/P charges are 45% higher than 2019; Percentages are comparable to 2019; Cost reports for 2019 and 2020 have high costs in comparison to IPCR. Allow as comparable % as 2019.

BHF Reconciliation - changed the adult days to agree with BHF Page 2