

# 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: Edward Hospital		Medicare Provider Number: 14-0231	
Street: 801 S. Washington Street		Medicaid Provider Number: 14002	
City: Naperville	State: Illinois	Zip: 60540	
Period Covered by Statement:	From: 01/01/2023	To: 12/31/2023	

## Type of Control

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> XXXX XXXX Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify)

## Type of Hospital

<input checked="" type="checkbox"/> XXXX XXXX General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other (Specify)

## Health Care Program

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

<input checked="" type="checkbox"/> XXXX XXXX Medicaid Hospital	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/>

**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)) Edward Hospital 14002 for the cost report beginning 01/01/2023 and ending 12/31/2023 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:	14-0231	Medicaid Provider Number:	14002
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2023 To: 12/31/2023

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
<b>Part I-Hospital</b>		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	223	81,395		70,879	87.08%		24,380	3.72
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	27	9,855		5,804	58.89%			
6.	Coronary Care Unit	22	8,030		6,096	75.92%			
7.	NICU	22	8,030		7,982	99.40%			
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	8,030		6,135	76.40%			
22.	<b>Total</b>	<b>316</b>	<b>115,340</b>		<b>96,896</b>	<b>84.01%</b>		<b>24,380</b>	<b>3.72</b>
23.	Observation Bed Days				15,219				

<b>Part II-Program</b>		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,527			732	3.26
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				156				
6.	Coronary Care Unit				167				
7.	NICU				535				
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				412				
22.	<b>Total</b>				<b>2,797</b>	<b>2.89%</b>		<b>732</b>	<b>3.26</b>

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:	
14-0231		14002	
Program:		Period Covered by Statement:	
Medicaid Hospital		From: 01/01/2023	To: 12/31/2023

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10 W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10 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	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)		(4)	(5)	(6)	(7)
1.	Operating Room	29,527,635	293,982,795	0.100440	1,554,557		156,140	
2.	Recovery Room	6,209,371	31,723,746	0.195733	110,972		21,721	
3.	Delivery and Labor Room	16,440,830	58,482,201	0.281125	478,806		134,604	
4.	Anesthesiology	1,914,564	191,391,720	0.010003	1,066,596		10,669	
5.	Radiology - Diagnostic	6,564,935	51,436,344	0.127632	353,105		45,067	
6.	Radiology - Therapeutic	66,219,856	387,204,453	0.171020	32,649		5,584	
7.	Nuclear Medicine	3,943,257	34,949,092	0.112829	41,729		4,708	
8.	Laboratory	15,419,685	350,021,280	0.044054	2,227,880		98,147	
9.	Blood							
10.	Blood - Administration	1,187,182	23,092,882	0.051409	240,510		12,364	
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,257,003	52,987,832	0.136956	2,207,065		302,271	
13.	Physical Therapy	4,589,531	33,468,169	0.137131	346,881		47,568	
14.	Occupational Therapy							
15.	Speech Pathology	1,344,853	9,111,325	0.147602	199,402		29,432	
16.	EKG	8,968,695	70,694,502	0.126866	630,416		79,978	
17.	EEG	1,210,193	26,737,509	0.045262	853,113		38,614	
18.	Med. / Surg. Supplies	96,167,409	173,603,628	0.553948	1,244,610		689,449	
19.	Drugs Charged to Patients	26,434,929	229,652,943	0.115108	4,082,611		469,941	
20.	Renal Dialysis							
21.	Ambulance							
22.	Endoscopy	7,034,816	73,056,468	0.096293	249,716		24,046	
23.	Ultrasound	2,806,295	40,288,039	0.069656	375,376		26,147	
24.	Women's Imaging	2,028,791	24,967,411	0.081258				
25.	Special Procedures	1,853,892	17,085,351	0.108508	230,868		25,051	
26.	CT Scan	6,182,546	265,407,783	0.023295	2,068,636		48,189	
27.	MRI	3,966,875	92,093,135	0.043075	613,149		26,411	
28.	Cardiac Cath	5,852,678	170,800,855	0.034266	469,430		16,085	
29.	EMG/NCV	78,999	1,460,601	0.054087	4,726		256	
30.	Impl Dev Charged	60,962,295	247,053,441	0.246758	943,643		232,851	
31.	ASC	9,479,344	15,776,457	0.600854	1,661		998	
32.	Cardiac Rehab	2,098,350	12,358,700	0.169787				
33.	Wound Ostomy	4,557,243	23,923,396	0.190493	6,059		1,154	
34.	Plainfield Clinic	48,288,818	489,920,169	0.098565	689,989		68,009	
35.	Oswego Clinic	915,987	21,195,659	0.043216				
36.	Bolingbrook Clinic	5,153,131	72,810,945	0.070774	15,471		1,095	
37.	Naperville North Clinic	380,137	4,578,363	0.083029				
38.	Outpatient Services	7,941,205	11,935,883	0.665322				
39.	Outpatient Clinic Other	10,659,490	109,109,424	0.097695				
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	6,383,631	23,323,336	0.273701	4,759		1,303	
44.	Emergency	33,014,957	326,799,108	0.101025	1,677,748		169,494	
45.	Observation	18,872,778	39,610,342	0.476461	42,555		20,276	
46.	<b>Total</b>				<b>23,064,688</b>		<b>2,807,622</b>	

\* 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

<b>Medicare Provider Number:</b> 14-0231	<b>Medicaid Provider Number:</b> 14002
<b>Program:</b> Medicaid Hospital	<b>Period Covered by Statement:</b> From: 01/01/2023 To: 12/31/2023

**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)	106,768,241			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	86,098			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,240.08			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,527			
3.	Program general inpatient routine cost (Line 1c X Line 2)	1,893,602			
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)	1,893,602			

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	13,562,166	5,804	2,336.69	156	364,524
9.	Coronary Care Unit	14,168,172	6,096	2,324.18	167	388,138
10.	NICU	14,295,132	7,982	1,790.92	535	958,142
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	4,827,235	6,135	786.84	412	324,178
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,807,622
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>6,736,206</b>

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

Preliminary

<b>Medicare Provider Number:</b>	<b>14-0231</b>	<b>Medicaid Provider Number:</b>	<b>14002</b>
<b>Program:</b>	<b>Medicaid Hospital</b>	<b>Period Covered by Statement:</b>	<b>From: 01/01/2023 To: 12/31/2023</b>

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.	NICU						
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:	14-0231	Medicaid Provider Number:	14002
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2023 To: 12/31/2023

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)
	<b>Inpatient Ancillary Cost Centers</b>	(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.	Endoscopy							
23.	Ultrasound							
24.	Women's Imaging							
25.	Special Procedures							
26.	CT Scan							
27.	MRI							
28.	Cardiac Cath							
29.	EMG/NCV							
30.	Impl Dev Charged							
31.	ASC							
32.	Cardiac Rehab							
33.	Wound Ostomy							
34.	Plainfield Clinic							
35.	Oswego Clinic							
36.	Bolingbrook Clinic							
37.	Naperville North Clinic							
38.	Outpatient Services							
39.	Outpatient Clinic Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>							

\* 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:	14-0231	Medicaid Provider Number:	14002
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2023 To: 12/31/2023

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.	NICU							
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>							
69.	<b>Total (Lines 67-68)</b>							

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

BHF Page 7

Preliminary

Medicare Provider Number: 14-0231		Medicaid Provider Number: 14002	
Program: Medicaid Hospital		Period Covered by Statement: From: 01/01/2023 To: 12/31/2023	
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)	6,736,206	
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)		
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.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>6,736,206</b>	
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)	23,064,688	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	2,882,531	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	868,346	
	F. Coronary Care Unit	933,168	
	G. NICU	3,330,007	
	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	606,420	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>31,685,160</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		24,948,954
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

<b>Medicare Provider Number:</b> 14-0231	<b>Medicaid Provider Number:</b> 14002
<b>Program:</b> Medicaid Hospital	<b>Period Covered by Statement:</b> From: 01/01/2023 To: 12/31/2023

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)	6,736,206	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,736,206	
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.	<b>Total Allowable Cost</b> (Sum of Lines 3 and 4, Plus or Minus Line 5)	6,736,206	

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.	<b>Balance Due Provider / (State Agency) *</b> (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

<b>Medicare Provider Number:</b>	<b>Medicaid Provider Number:</b>
14-0231	14002
<b>Program:</b>	<b>Period Covered by Statement:</b>
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

**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)	24,948,954
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 (4)	Sum of Columns 1 - 4 (5)
		to	to	to		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

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

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio	Amount (Col. 1x2A) (2B)	Ratio	Amount (Col. 1x3A) (3B)
			(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**

<b>Medicare Provider Number:</b> 14-0231	<b>Medicaid Provider Number:</b> 14002
<b>Program:</b> Medicaid Hospital	<b>Period Covered by Statement:</b> From: 01/01/2023 To: 12/31/2023

**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

<b>Medicare Provider Number:</b>	<b>Medicaid Provider Number:</b>
14-0231	14002
<b>Program:</b>	<b>Period Covered by Statement:</b>
Medicaid Hospital	From: 01/01/2023 To: 12/31/2023

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)
	<b>Inpatient Ancillary Centers</b>	(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.	Endoscopy							
23.	Ultrasound							
24.	Women's Imaging							
25.	Special Procedures							
26.	CT Scan							
27.	MRI							
28.	Cardiac Cath							
29.	EMG/NCV							
30.	Impl Dev Charged							
31.	ASC							
32.	Cardiac Rehab							
33.	Wound Ostomy							
34.	Plainfield Clinic							
35.	Oswego Clinic							
36.	Bolingbrook Clinic							
37.	Naperville North Clinic							
38.	Outpatient Services							
39.	Outpatient Clinic Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>							

\* 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:	14-0231	Medicaid Provider Number:	14002
Program:	Medicaid Hospital	Period Covered by Statement:	From: 01/01/2023 To: 12/31/2023

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.	NICU							
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.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>							
69.	<b>Total (Lines 67-68)</b>							

## Preliminary

Medicare Provider Number: 14-0231	Medicaid Provider Number: 14002
Program: Medicaid Hospital	Period Covered by Statement: From: 01/01/2023 To: 12/31/2023

	Provider's Records	Adjustments	Audited Cost Report
<b>Inpatient Reconciliation</b>			
Adult Days	2,385		2,385
Newborn Days	412		412
Total Inpatient Revenue	31,689,607	(4,447)	31,685,160
Ancillary Revenue	23,069,134	(4,446)	23,064,688
Routine Revenue	8,620,473	(1)	8,620,472
Inpatient Received and Receivable			
<b>Outpatient Reconciliation</b>			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

[illegible]