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Owner	Shannon Hartke: Director, Revenue Cycle
Area	Patient Financial Services
Applicability	Southern Illinois Healthcare Corporate System

Epic HB - Price Transparency, SY-PF-356

I. POLICY

SIH is committed to price transparency and has posted charges for services in accordance with Centers for Medicare and Medicaid Services (CMS) as listed in the final rule, CMS-1717-F2, Price Transparency Requirements for Hospitals to Make Standard Charges Public. Additionally, in accordance with the Affordable Care Act, Section 2718(e) of the Public Health Service Act, all of Southern Illinois Healthcare's (SIH) hospital standard charges are available as a comprehensive machine-readable file and displayed on the website; 45 CFR 180.20 and subsequent revisions found within 45 CFR 180.50.

The information presented is a tool to assist consumers to shop and compare prices with any hospital operating a license in the United States prior to receiving service. However, it is likely not a helpful tool for a patient to know what their financial obligation will be as patient care is highly individualized, based on medical necessity, and ultimately processed under their insurance plan benefit design. It is intended to promote transparency in hospital pricing as well as for patients to engage in consumer-based communications with their health insurance plan to understand their potential financial liability for services rendered.

II. DEFINITIONS

835 EDI - 835 Electronic Data Interchange known in the industry as the 835 Electronic Remittance Advice (ERA).

Chief Executive Officer, President, or Senior Official - the individual designated to oversee the encoding of true, accurate, and complete data.

CMS - Centers for Medicare & Medicaid Services

De-identified Maximum Negotiated Charge - the highest charge a hospital has negotiated with all third party payers for an item or service.

De-identified Minimum Negotiated Charge - the lowest charge a hospital has negotiated with all third party payers for an item or service.

Discounted Cash Price - the price which applies to an individual who pays cash or the cash equivalent for a hospital item or service.

Diagnostic Related Group (DRG) - DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital.

Encode - to convert hospital standard charge information into a machine-readable format.

Epic – electronic medical record used to bill or follow-up on patient accounts and scan information received or printed on behalf of a patient.

Epic Dynamic Charge Description Master – a file/dictionary in the Epic billing system where a list of items, services, and/or charges reside and are defined to establish a charge(s).

Estimated Allowed Amount - the average dollar amount that the hospital has historically received from a third party payer for an item or service. As of January 1, 2026, is now stated as the Median Allowed

Gross Charge - the charge for an individual item or service as reflected on the hospital's charge-master, absent any discounts.

Health-care Common Procedure Coding System - (HCPCS) is a standardized code system necessary for medical providers to submit health-care claims to Medicare and other health insurances in a consistent and orderly manner. HCPCS includes two medical code sets, HCPCS Level I and HCPCS Level II.

Hospital Charges / Uniform Charges – the amounts set before any discounts. Hospitals are required by federal regulations to utilize uniform charges as the starting point for all bills and also defined as gross charge(s). Charges are based on what type of care was provided and can differ from patient to patient for the same service depending on any complications or differences in treatment plans provided, as ordered by the physician, due to the patient’s health. Therefore, actual total charges to a specific patient most likely differ from the average charge per case.

Items and Services - means all items and services, including individual items and services and packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a gross charge.

Lookback Period - No less than 12 months and no longer than15 months.

Machine-Readable Format - a single digital file that is in a machine-readable format.

Median Allowed Amount - denoting or relating to a value or quantity lying at the midpoint of a frequency distribution of observed values or quantities, denoting the middle term. However, hospitals are instructed to use the next highest observed value, per CMS.

Modifiers - two characters (letters or numbers) appended to a CPT ® or HCPCS Level II code. The

modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code.

National Drug Code - Drugs are identified and reported using a unique, three-segment number called the National Drug Code (NDC) which serves as the Food and Drug Administration's identifier for drugs.

Payer-Specific Negotiated Charge - the charge that a hospital has negotiated with a third party payer for an item or service.

Revenue Center Codes - (RCC) Revenue codes are a set of standardized 4-digit numbers used in medical billing. Revenue codes are set by the National Uniform Billing Committee (NUBC). This means every health-care provider gives standardized information when billing.

Third Party Payer - an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for health-care item(s) or service(s).

III. RESPONSIBILITIES

1. The Corporate Director of Patient Financial Services, Corporate Director of Finance, and the IT Analyst ensures price transparency by posting a list of Inpatient and Outpatient charges on the internet with at least annual updates.
2. Executive Director of Managed Care and Physician Hospital Organization (PHO) is responsible for compiling the data.
3. SIH Corporate Compliance Officer is a point of contact for all SIHS Hospital locations.
4. The Sr. VP Chief Financial Officer & Treasurer is the individual designated to oversee the encoding of true, accurate, and complete data.

IV. EQUIPMENT/MATERIALS

1. Epic
2. Epic Dynamic Charge Description Master
3. Hospital Information System

V. PROCEDURE

1. SIH is committed to price transparency and has posted the required elements as defined in the Final Rule, CMS- 1717-F2 for items and services.
    1. This list may not prove helpful for a patient to know what their financial obligation will be as many factors which include; the care which is provided can and often differs from patient to patient for the same service depending on any complications or differences in treatment plans provided, as ordered by the physician, due to the patient's health.
2. Physician Services, are not included in the price transparency files as these charges are separately billable and are not part of the regulation. Patients will receive additional charges and billing statements for these professional services. Examples include but are not limited to

the following: Pathology, Cardiology, Radiology report and interpretation results/services, Anesthesia professional services, and other miscellaneous professional services.

1. The physicians, physician assistants, and advanced practice nurses for whose services are being billed are not employees or agents of Southern Illinois Hospital Services d/b/a Memorial Hospital of Carbondale, Herrin Hospital, or St. Joseph Memorial Hospital.

3. Third Party Payers not included in this policy are identified as payers who are governed by State and Federal regulatory bodies which display their allowed/payable amounts via a fee schedule. These amounts are viewable by the general public free of charge and listed on various websites to include:
    1. Crime Victims Compensation Program
    2. Indian Health Programs
    3. Medicare
    4. Medicaid
    5. Veterans Administration
    6. Workers Compensation
    7. Any payers which the rates are not negotiated - Includes but not limited to SIH self-Insured plan.

4. Requirements for making public hospital charge(s) for all items and services include:
    1. Each hospital operating under a single hospital license must include price transparency files which are publicly displayed on the website and include the following:
        a. Hospital name and location
        b. File naming convention in a CMS approved format
            i. Tax identification Number <ein>
            ii. National Provider Identification (NPI)
            iii. Hospital Name
            iv. Standard charges in the |JSON| file format.
        c. Standard charges for the purpose of this policy are defined as items and services, hospital charges / uniformed charges and/or gross charges. Standard charge commonly means the regular rate established by the hospital for an item or service provided to a specific group of paying patients and includes
            i. Gross Charges
            ii. Payer-specific negotiated charge
            iii. De-identified minimum negotiated charge
            iv. De-identified maximum negotiated charge
            v. Discounted cash price

a. The discounted cash price is the amount paid by the patient who elects not to bill their insurance and reimburse the hospital 80% of gross charges.

2. A description of each item or service provided by the hospital in a machine-readable format free of charge.
    a. SIH reserves the right to consolidate services among their location, thus not all services are offered at each location with the exception of emergency services.
3. Gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
4. Payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
    a. Each payer- specific negotiated charge is clearly associated with the name of the third party payer and plan.
5. De-identified minimum negotiated charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
6. De-identified maximum negotiated charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
7. Discounted cash price that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
8. Codes used by the hospital for purposes of accounting or billing for items or services, including, but not limited to the Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis Related Group (DRG), National Drug Code (NDC) or other common payer identifier.
    a. This policy includes codes or charges used to hold or monitor claims for final processing, working appeals and/or general tracking mechanisms, and minimal values such as zero or penny charges.

5. Average charges by Diagnostic Related Group (DRG) as listed in the price transparency file and displayed on the internet.
    1. These are total average charges by DRG for recent inpatients at each hospital. These charges include items such as room and bed, and, as applicable, surgical and recovery services, lab tests, imaging exams and other services ordered by clinicians for the care of the patient generally described as facility fees.
    2. Actual charges could vary significantly by patient since they are influenced by their medical condition, length of stay, procedures and medications ordered by a clinician and other various factors.
    3. Any DRG in which the hospital(s) lacks charge history or service is not performed in the annual reporting period is excluded.
        a. DRG history from other locations will not be included when looking up

historical values as not all DRGs are performed at each location.

b. The DRG median case amount will be displayed in the machine-readable file.

6. The format of the information is published in a single |JSON| digital file per facility in a search-able machine-readable format.
7. The location of the files are listed on the SIH public website, www.sih.net, for purposes of public viewing, with the intent to prominently display in a location of vast accessibility in a prominent manner and clearly identified.
    1. Files can be located on www.sih.net, see Patients & Visitors then select Financial Resources
    2. A link in the footer on the SIH homepage website; labeled Price Transparency, links directly to the publicly available web page hosting the machine-readable file.
8. This information is easily accessible, without barriers, and is free of charge.
    1. In addition to the information being available free of charge; reviewing or searching for information will not require a registration, a user account or password, nor any personally identifying information (PII).
    2. SIH has no obligation to reproduce files in any form of media based on a patient's request.
9. The files will be updated with the standard charge information listed above at least once annually and timing determined by SIH. The updated file will be clearly indicate the date the standard charge data was most recently updated either within the file itself or otherwise clearly associated with the file.
    1. Informational and machine-readable files will be update the first calendar month of SIHS Fiscal Year which begins each April.
    2. Files from previous years will not be retained on the website or reproduced in any manner of media.
10. The SIH Corporate Compliance Officer, located at Southern Illinois Hospital Services Corporate Office, is the single point of contact for information regarding Price Transparency.
    1. SIH Corporate Compliance Officer can be contacted at 618-457-5200 or email at Jessica.Kranawetter@sih.net.
11. Requests for specific price estimates are not covered in this policy and are directed to the Financial Counselor or by sending a MyChart request for further assistance. Refer to SY-PF-355
    1. Patient Estimates Financial Counselors can be reached at the numbers listed below.
        A. Memorial Hospital of Carbondale 618-549-0721 ext. 64572
        B. Herrin Hospital 618-942-2171 ext 36458
        C. St. Joseph Memorial Hospital 618-684-3156 ext 55331
12. New Requirements for Making Public Hospital Standard Charges under 45 CFR 180.50 beginning July 1, 2024.

1. Good Faith Effort - True and Correct: Affirm its machine-readable file that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information and that the information encoded is true, accurate, and complete as the date indicated in the machine-readable file.
2. General data elements include:
    a. Hospital Name,
    b. License Number
    c. Location Name and Address
    d. The version Number of CMS template
    e. The date of the most recent update to the standard charge information in the machine-readable file.
3. Methods used to establish the standard charge and whether the standard charge indicated should be interpreted by the user as a dollar amount, or if the standard charge is based on a percentage or algorithm.
4. A general description of the item or service
    a. Whether the item or service is provided in connection with an inpatient admission or outpatient department visit.
5. Medication Information: Medication values display the unit price associated with the quantity. The NDC packaging size price will be displayed.

13. Beginning January 1, 2025 requirements for drugs include the drug unit and type of measurement
    1. Other general provisions include coding information, other common payer identifiers, and modifiers.
        a. Coding information includes: any codes used by the hospital for purposes of accounting or billing for the item or service.
        b. Corresponding code types includes: Such code types may include, but are not limited to, the CPT Code, HCPCS code, the DRG, the NDC, Revenue Center Codes, or other common payer identifier and
        c. Modifiers that may change the standard charge that corresponds to a hospital item or service, including a description of the modifier and how it change the standard charge.

14. Beginning January 1, 2026 Executive Order 14221 was signed providing CMS the authority to implement the following changes to Price Transparency regulations.
    1. Replaced the estimated allowed amount with the median allowed amount
    2. Instructed hospitals to include 10th and 90th percentile allowed amounts listed in dollars.
        a. CMS finalized the requirement that hospitals use electronic data interchange (EDI) 835 electronic remittance advices (ERA) or an alternative, equivalent source of remittance data to calculate and encode

the median, 10th and 90th percentile amounts and count.

3. Hospitals must also include the encode of count of allowed amounts that were used to calculate the median 10th and 90th percentile allowed amount data elements.
4. CMS finalized the requirement that hospital use a lookback period of no less than 12 months and no longer than 15 months prior to posting the machine readable file.
5. CMS has required hospitals to encode in the machine readable file the name of the hospital executive designated to oversee the encoding of true, accurate, and complete data.
    a. SIHS has designated, Sr. VP Chief Financial Officer & Treasurer, Warren P. Ladner

VI. DOCUMENTATION

N/A

VII. CHARGES

N/A

REPLACES

Approval Signatures

Step Description	Approver	Date
	Andrew Ziramba: Regulatory Coordinator	2/20/2026
	Warren Ladner: SR VP & CFO	2/20/2026
	Shannon Hartke: Director, Revenue Cycle	2/17/2026
	Jessica Kranawetter: Director, Audit & Corporate Compliance	2/17/2026
	Julie Gwaltney	2/17/2026
	Jenny Hertter: Executive Director, Managed Care and Physician Hos	2/17/2026
	Jennifer Granados: Director, Finance	2/17/2026

Applicability

Southern Illinois Healthcare Corporate System