Hospital Statement of Cost

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

General Information

Preliminary

Name of Hospital: Methodist Medical Center of Illinois			**Medicare Provider Number:** 14-0209
Street: 221 N E Glen Oak			**Medicaid Provider Number:** 16006
City: Peoria	**State:** Illinois	**Zip:** 61636	
Period Covered by Statement:	**From:** 01/01/2023	**To:** 12/31/2023	

Type of Control

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

Type of Hospital

[XXXX]	General Short-Term	[ ]	Psychiatric	[ ]	Cancer
[ ]	General Long-Term	[ ]	Rehabilitation	[ ]	Other (Specify)

Health Care Program

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

[ ]	Medicaid Hospital	[ ]	Medicaid Sub II Rehab	[ ]	
[XXXX]	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)) Methodist Medical Center of Il 16006 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)	Name (Typewritten)
Title / Date	Title
Firm	Date
Telephone Number	Telephone Number
Email Address	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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	177	64,605		41,907	64.87%		10,143	4.80
2.	Psych	44	16,060		13,109	81.63%		1,617	8.11
3.	Rehab	25	8,375		4,998	59.68%		405	12.34
4.	Other (Sub)								
5.	Intensive Care Unit	14	5,110		3,671	71.84%			
6.	Coronary Care Unit								
7.	Surgical ICU	12	4,380		3,102	70.82%			
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	20	7,300		3,892	53.32%			
22.	**Total**	**292**	**105,830**		**70,679**	**66.79%**		**12,165**	**5.49**
23.	Observation Bed Days				4,919				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				956			123	7.77
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Surgical ICU								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery								
22.	**Total**				**956**	**1.35%**		**123**	**7.77**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
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)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	40,158,108	180,643,026	0.222306				
2.	Recovery Room	6,050,548	49,118,987	0.123181				
3.	Delivery and Labor Room	3,732,666	12,346,388	0.302329				
4.	Anesthesiology	3,602,438	104,649,378	0.034424				
5.	Radiology - Diagnostic	14,375,767	56,576,614	0.254094	12,236		3,109	
6.	Radiology - Therapeutic	4,205,720	44,941,870	0.093581				
7.	Nuclear Medicine	2,551,408	12,950,329	0.197015				
8.	Laboratory	29,463,074	339,130,554	0.086878	205,205		17,828	
9.	Blood							
10.	Blood - Administration	2,022,504	8,070,364	0.250609				
11.	Intravenous Therapy	2,249,557	28,400,348	0.079209	2,437		193	
12.	Respiratory Therapy	4,068,112	34,996,285	0.116244	53,444		6,213	
13.	Physical Therapy	5,225,607	10,090,449	0.517877	2,264		1,172	
14.	Occupational Therapy	1,376,438	5,545,615	0.248203	468		116	
15.	Speech Pathology	627,156	2,521,015	0.248771	1,112		277	
16.	EKG	1,261,756	11,231,656	0.112339	26,639		2,993	
17.	EEG	1,268,358	6,114,090	0.207448	10,680		2,216	
18.	Med. / Surg. Supplies	6,100,841	75,498,548	0.080807				
19.	Drugs Charged to Patients	26,677,944	109,458,055	0.243728	32,584		7,942	
20.	Renal Dialysis	1,025,939	3,123,907	0.328415				
21.	Ambulance							
22.	Pain Clinic	1,119,367	4,033,017	0.277551				
23.	Northside Imaging	709,285	2,481,150	0.285869				
24.	Northside Mammography	385,570	1,937,405	0.199014				
25.	Northside Ultrasound	2,293						
26.	CT Scan	2,668,927	92,762,502	0.028772	29,717		855	
27.	Northside CT	447,055	8,323,062	0.053713				
28.	MRI	1,953,507	27,487,436	0.071069	30,990		2,202	
29.	Northside MRI	1,096,044	11,237,758	0.097532				
30.	Cardiac Cath	3,202,441	58,993,377	0.054285				
31.	Implantable Devices	23,805,622	94,948,866	0.250720				
32.	Psych Services	1,661,233	2,818,840	0.589332				
33.	GI	7,143,049	28,193,743	0.253356				
34.	Cardiology	7,590,094	24,840,548	0.305553				
35.	Pulmonary Function	342,470	5,471,236	0.062595				
36.	Hyperbaric Oxygen	467,403	1,685,651	0.277283				
37.	Physician Offices	24,914,914	63,533,077	0.392157				
38.	Diabetic Care Center	1,945,664	4,255,776	0.457182				
39.	Wound Care Center	1,139,508	4,621,742	0.246554				
40.	Other Clinics	17,025,759	32,573,374	0.522689				
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	8,359,443	38,719,728	0.215896				
44.	Emergency	24,430,309	120,912,908	0.202049	5,896		1,191	
45.	Observation	6,962,303	9,312,574	0.747624				
46.	**Total**				**413,672**		**46,307**	

* 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	66,277,109	15,487,962	2,471,097	
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	46,826	13,109	4,998	
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,415.39	1,181.48	494.42	
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		956		
3.	Program general inpatient routine cost (Line 1c X Line 2)		1,129,495		
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)		1,129,495		

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	13,359,997	3,671	3,639.33		
9.	Coronary Care Unit					
10.	Surgical ICU	1,828,671	3,102	589.51		
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	1,862,901	3,892	478.65		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					46,307
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,175,802**

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2023 To: 12/31/2023

Line No.	Hospital Inpatient Services	Percent of Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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.	Surgical ICU						
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 Assign-able Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Alloca-tion (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)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	**Total (Sum of Lines 22 and 26)**								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

BHF Page 6(a)

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)
	Inpatient Ancillary Cost Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	CT Scan							
27.	Northside CT							
28.	MRI							
29.	Northside MRI							
30.	Cardiac Cath							
31.	Implantable Devices							
32.	Psych Services							
33.	GI							
34.	Cardiology							
35.	Pulmonary Function							
36.	Hyperbaric Oxygen							
37.	Physician Offices							
38.	Diabetic Care Center							
39.	Wound Care Center							
40.	Other Clinics							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost 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 professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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.	Surgical ICU							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	1,175,802	
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)	45	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,175,847**	
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)	413,672	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	2,578,395	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Surgical ICU		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	2,992,067	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		1,816,220
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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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)	1,175,847	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,175,847	
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)**	**1,175,847**	

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.

Rev. 10 / 11

Hospital Statement of Cost / Recovery of Excess Reasonable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
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)	1,816,220
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 to	to	to	Current Cost Reporting Period	Sum of Columns 1 - 4
		(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 **BHF Supplement No. 1**
Teaching Physicians / Routine Services Questionnaire
Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	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

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
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)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	449,685	180,643,026	0.002489				
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	95,940	56,576,614	0.001696	12,236		21	
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.	Pain Clinic							
23.	Northside Imaging							
24.	Northside Mammography							
25.	Northside Ultrasound							
26.	CT Scan							
27.	Northside CT							
28.	MRI							
29.	Northside MRI							
30.	Cardiac Cath							
31.	Implantable Devices							
32.	Psych Services							
33.	GI	202,211	28,193,743	0.007172				
34.	Cardiology							
35.	Pulmonary Function							
36.	Hyperbaric Oxygen							
37.	Physician Offices	4,756,623	63,533,077	0.074868				
38.	Diabetic Care Center							
39.	Wound Care Center	81,179	4,621,742	0.017565				
40.	Other Clinics							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,997,473	38,719,728	0.103241				
44.	Emergency	482,157	120,912,908	0.003988	5,896		24	
45.	Observation							
46.	**Ancillary Total**						**45**	

* 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:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
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 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	2,243,997	46,826	47.92				
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	408,357	3,671	111.24				
52.	Coronary Care Unit							
53.	Surgical ICU	41,328	3,102	13.32				
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	52,152	3,892	13.40				
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**						**45**	
69.	**Total (Lines 67-68)**						**45**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0209	16006
Program:	**Period Covered by Statement:**
Medicaid-Hospital	From: 01/01/2023 To: 12/31/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	995	(39)	956
Newborn Days			
Total Inpatient Revenue	2,978,357	13,710	2,992,067
Ancillary Revenue	403,680	9,992	413,672
Routine Revenue	2,574,677	3,718	2,578,395
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Reclassed the Part I-Hospital CCU beds and days to Surgical ICU to agree with Medicare report
BHF Page 2 - Adjusted the Part II-Program days to agree with the IPCR
BHF Page 2 - Adjusted the Part II-Program discharges to agree with the Part I-Hospital average length of stay
BHF Page 3 - Reclassed blood costs/charges to blood admin costs/charges
BHF Page 3 - Other clinics contain lines 90.04, 90.08-90.14 of W/S C, Part I of the Medicare report
BHF Page 3 - Adjusted the I/P charges to agree with the IPCR
BHF Page 6a & 6b - Adjusted out the professional fees as none on the IPCR
BHF Page 7 - Adjusted the Routine charges to agree with the IPCR