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: Northwestern Lake Forest Hospital	**Medicare Provider Number:** 14-0130
Street: 1000 Westmoreland Road	**Medicaid Provider Number:** 12002
City: Lake Forest	**State:** Illinois / **Zip:** 60045
Period Covered by Statement:	**From:** 09/01/2022 / **To:** 08/31/2023

Type of Control

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

[XXXX]	Medicaid Hospital	[ ]	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)) Northwestern Lake Forest Ho: 12002 for the cost report beginning 09/01/2022 and ending 08/31/2023 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):

Name (Typewritten)
Title Date
Firm
Telephone Number
Email Address

Signed (Officer or Administrator of Provider(s)):

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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	110	40,150		40,120	99.93%		13,263	3.35
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	12	4,380		4,312	98.45%			
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				3,889				
22.	**Total**	**122**	**44,530**		**48,321**	**108.51%**		**13,263**	**3.35**
23.	Observation Bed Days				6,491				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				1,671			496	3.58
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				104				
6.	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				85				
22.	**Total**				**1,860**	**3.85%**		**496**	**3.58**

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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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	52,112,642	405,485,516	0.128519	2,603,948		334,657	
2.	Recovery Room							
3.	Delivery and Labor Room	10,388,258	24,845,557	0.418113	276,462		115,592	
4.	Anesthesiology							
5.	Radiology - Diagnostic	32,468,970	283,301,713	0.114609	999,624		114,566	
6.	Radiology - Therapeutic	6,100,989	73,804,352	0.082664	80,411		6,647	
7.	Nuclear Medicine							
8.	Laboratory	28,903,569	283,298,932	0.102025	4,668,010		476,254	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	6,375,956	32,881,206	0.193909	733,525		142,237	
13.	Physical Therapy	3,575,968	15,113,920	0.236601				
14.	Occupational Therapy							
15.	Speech Pathology	2,122,118	7,005,747	0.302911	885		268	
16.	EKG	4,127,665	80,313,004	0.051395	866,121		44,514	
17.	EEG	2,188,773	8,314,302	0.263254	98,009		25,801	
18.	Med. / Surg. Supplies	16,405,235	160,204,433	0.102402	1,615,792		165,460	
19.	Drugs Charged to Patients	106,891,166	542,551,053	0.197016	1,991,150		392,288	
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	5,523,153	153,345,905	0.036018	2,546,887		91,734	
23.	Cardiac Catherization	9,081,151	78,979,784	0.114981	1,529,890		175,908	
24.	Implement Dev.Charged	19,007,771	100,077,437	0.189931	484,852		92,088	
25.	MRI	8,040,334	148,984,401	0.053968	1,177,040		63,522	
26.	Cardiac Rehabilitation	4,254,257	2,906,638	1.463635				
27.	Wound Clinic	6,779,068	18,294,341	0.370555				
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	7,322,911	37,892,357	0.193256	8,130		1,571	
44.	Emergency	27,983,098	255,293,225	0.109612	1,622,805		177,879	
45.	Observation	15,852,221	49,382,376	0.321010	147,050		47,205	
46.	**Total**				**21,450,591**		**2,468,191**	

* 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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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)	74,116,382			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	46,611			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,590.10			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	1,671			
3.	Program general inpatient routine cost (Line 1c X Line 2)	2,657,057			
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)	2,657,057			

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	21,031,972	4,312	4,877.54	104	507,264
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	5,524,479	3,889	1,420.54	85	120,746
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,468,191
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**5,753,258**

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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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.	Other						
9.	Other						
10.	Other						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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.	CT Scan							
23.	Cardiac Catherization							
24.	Implement Dev.Charged							
25.	MRI							
26.	Cardiac Rehabilitation							
27.	Wound Clinic							
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Cost Centers							
43.	Clinic							
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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	**Routine Total (lines 47-66)**							
68.	**Ancillary Total (from line 46)**							
69.	**Total (Lines 67-68)**							

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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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)	5,753,258	
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)	73,563	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**5,826,821**	
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)	21,450,591	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	5,520,986	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	2,381,960	
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	496,273	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	29,849,810	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		24,022,989
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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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)	5,826,821	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	5,826,821	
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)**	**5,826,821**	

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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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)	24,022,989
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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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	537,284	405,485,516	0.001325	2,603,948		3,450	
2.	Recovery Room							
3.	Delivery and Labor Room	45,796	24,845,557	0.001843	276,462		510	
4.	Anesthesiology							
5.	Radiology - Diagnostic	720,837	283,301,713	0.002544	999,624		2,543	
6.	Radiology - Therapeutic	183,420	73,804,352	0.002485	80,411		200	
7.	Nuclear Medicine							
8.	Laboratory	131,354	283,298,932	0.000464	4,668,010		2,166	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	22,052	32,881,206	0.000671	733,525		492	
13.	Physical Therapy	1,962	15,113,920	0.000130				
14.	Occupational Therapy							
15.	Speech Pathology	7,135	7,005,747	0.001018	885		1	
16.	EKG	35,771	80,313,004	0.000445	866,121		385	
17.	EEG	63,580	8,314,302	0.007647	98,009		749	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	CT Scan	397,350	153,345,905	0.002591	2,546,887		6,599	
23.	Cardiac Catherization	304,485	78,979,784	0.003855	1,529,890		5,898	
24.	Implement Dev.Charged							
25.	MRI	246,716	148,984,401	0.001656	1,177,040		1,949	
26.	Cardiac Rehabilitation	9,625	2,906,638	0.003311				
27.	Wound Clinic	2,251	18,294,341	0.000123				
28.	Other							
29.	Other							
30.	Other							
31.	Other							
32.	Other							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	3,262	37,892,357	0.000086	8,130		1	
44.	Emergency	50,997	255,293,225	0.000200	1,622,805		325	
45.	Observation	1,167	49,382,376	0.000024	147,050		4	
46.	**Ancillary Total**						**25,272**	

* 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:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

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	1,299,124	46,611	27.87	1,671		46,571	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	68,184	4,312	15.81	104		1,644	
52.	Coronary Care Unit							
53.	Other							
54.	Other							
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	3,475	3,889	0.89	85		76	
67.	**Routine Total (lines 47-66)**						**48,291**	
68.	**Ancillary Total (from line 46)**						**25,272**	
69.	**Total (Lines 67-68)**						**73,563**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0130	12002
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	1,775		1,775
Newborn Days	85		85
Total Inpatient Revenue	29,849,807	3	29,849,810
Ancillary Revenue	21,450,589	2	21,450,591
Routine Revenue	8,399,218	1	8,399,219
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 6a & 6b - Adjusted out the professional fees as none on the IPCR
BHF Supplemental 2a & 2b - Adjusted the GME costs to agree with W/S B, Part I, Col 25 of the Medicare report
Minor rounding adjustment