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: Ann & Robert Lurie Children's Hospital		**Medicare Provider Number:** 14-3300	
Street: 225 E. Chicago Ave.		**Medicaid Provider Number:** 3025	
City: Chicago	**State:** Illinois	**Zip:** 60611-2605	
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

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

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)) Ann & Robert Lurie Children's 3025 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:
14-3300	3025
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	152	55,480		42,466	76.54%		9,897	9.49
2.	Psych	12	4,380		3,507	80.07%		394	8.90
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	92	33,580		14,837	44.18%			
6.	Coronary Care Unit	44	16,060		14,811	92.22%			
7.	Neonatal ICU	64	23,360		21,762	93.16%			
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**	**364**	**132,860**		**97,383**	**73.30%**		**10,291**	**9.46**
23.	Observation Bed Days				9,152				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				4,702			831	11.22
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				827				
6.	Coronary Care Unit				1,830				
7.	Neonatal ICU				1,966				
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**				**9,325**	**9.58%**		**831**	**11.22**

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:
14-3300	3025
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	94,422,638	528,666,589	0.178605	9,016,417		1,610,377	
2.	Recovery Room	7,567,202	34,831,117	0.217254	159,904		34,740	
3.	Delivery and Labor Room							
4.	Anesthesiology	6,248,630	85,218,116	0.073325	1,223,649		89,724	
5.	Radiology - Diagnostic	15,057,252	117,903,908	0.127708	2,732,431		348,953	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	65,529,513	464,998,572	0.140924	15,860,309		2,235,098	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	34,024,985	179,934,259	0.189097	32,082,590		6,066,722	
13.	Physical Therapy	10,122,362	21,675,766	0.466990	507,435		236,967	
14.	Occupational Therapy	3,521,392	9,615,727	0.366212	328,598		120,337	
15.	Speech Pathology	14,724,625	30,959,921	0.475603	374,127		177,936	
16.	EKG	7,399,534	20,493,544	0.361067	209,996		75,823	
17.	EEG	7,943,447	51,214,853	0.155100	1,046,630		162,332	
18.	Med. / Surg. Supplies	38,534,342	60,658,808	0.635264	1,237,583		786,192	
19.	Drugs Charged to Patients	93,437,552	480,417,850	0.194492	27,044,447		5,259,929	
20.	Renal Dialysis	2,688,461	7,962,133	0.337656	664,904		224,509	
21.	Ambulance							
22.	CT Scan	7,729,151	41,422,027	0.186595	624,875		116,599	
23.	MRI	7,658,249	110,470,921	0.069324	3,850,660		266,943	
24.	Cardiac Cath	16,520,782	163,515,142	0.101035	1,494,688		151,016	
25.	Impants	29,981,963	63,597,837	0.471431	1,576,417		743,172	
26.	Psych	21,558,228	18,532,737	1.163251				
27.	Kidney Acquisition	2,017,042	2,761,346	0.730456				
28.	Heart Acquisition	3,341,488	2,299,962	1.452845				
29.	Liver Acquisition	1,717,382	1,533,308	1.120050				
30.	Intestine Acquisition	42,606						
31.	Outpatient Pharmacy							
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	151,916,512	129,234,159	1.175514	151,196		177,733	
44.	Emergency	41,070,896	146,595,202	0.280165	1,663,810		466,141	
45.	Observation	20,997,708	41,480,934	0.506201				
46.	**Total**				**101,850,666**		**19,351,243**	

* 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:
14-3300	3025
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)	118,428,706	8,046,214		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	51,618	3,507		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	2,294.33	2,294.33		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	4,702			
3.	Program general inpatient routine cost (Line 1c X Line 2)	10,787,940			
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)	10,787,940			

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	87,466,951	14,837	5,895.19	827	4,875,322
9.	Coronary Care Unit	51,060,302	14,811	3,447.46	1,830	6,308,852
10.	Neonatal ICU	63,160,581	21,762	2,902.33	1,966	5,705,981
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					
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					19,351,243
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**47,029,338**

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:
14-3300	3025
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.	Neonatal 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

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-3300	3025
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.	MRI							
24.	Cardiac Cath							
25.	Impants							
26.	Psych							
27.	Kidney Acquisition							
28.	Heart Acquisition							
29.	Liver Acquisition							
30.	Intestine Acquisition							
31.	Outpatient Pharmacy							
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:
14-3300	3025
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.	Neonatal 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:
14-3300	3025
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)	47,029,338	
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)	1,412,321	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**48,441,659**	
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)	101,850,666	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	10,435,604	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	25,960,761	
	F. Coronary Care Unit	29,135,587	
	G. Neonatal ICU	11,733,070	
	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)**	179,115,688	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		130,674,029
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:
14-3300	3025
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 09/01/2022 To: 08/31/2023

Line No.	Allowable Cost	Program Inpatient (1)	Program Outpatient (2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	48,441,659	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	48,441,659	
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)**	**48,441,659**	

Line No.	Total Amount Received / Receivable	Program Inpatient (1)	Program Outpatient (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:
14-3300	3025
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)	130,674,029
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:
14-3300	3025
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:
14-3300	3025
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	4,835,750	528,666,589	0.009147	9,016,417		82,473	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology	2,672,388	85,218,116	0.031359	1,223,649		38,372	
5.	Radiology - Diagnostic	1,781,592	117,903,908	0.015111	2,732,431		41,290	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	3,054,158	464,998,572	0.006568	15,860,309		104,171	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	509,026	179,934,259	0.002829	32,082,590		90,762	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	890,796	20,493,544	0.043467	209,996		9,128	
17.	EEG	1,018,053	51,214,853	0.019878	1,046,630		20,805	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	509,026	7,962,133	0.063931	664,904		42,508	
21.	Ambulance							
22.	CT Scan							
23.	MRI							
24.	Cardiac Cath	636,283	163,515,142	0.003891	1,494,688		5,816	
25.	Impants							
26.	Psych	1,527,079	18,532,737	0.082399				
27.	Kidney Acquisition							
28.	Heart Acquisition							
29.	Liver Acquisition							
30.	Intestine Acquisition							
31.	Outpatient Pharmacy							
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	763,539	129,234,159	0.005908	151,196		893	
44.	Emergency	3,690,441	146,595,202	0.025174	1,663,810		41,885	
45.	Observation							
46.	**Ancillary Total**						**478,103**	

* 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:
14-3300	3025
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	7,387,963	51,618	143.13	4,702		672,997	
48.	Psych	501,949	3,507	143.13				
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	2,417,876	14,837	162.96	827		134,768	
52.	Coronary Care Unit							
53.	Neonatal ICU	1,399,823	21,762	64.32	1,966		126,453	
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)**						**934,218**	
68.	**Ancillary Total (from line 46)**						**478,103**	
69.	**Total (Lines 67-68)**						**1,412,321**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-3300	3025	
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	9,325		9,325
Newborn Days			
Total Inpatient Revenue	179,115,688		179,115,688
Ancillary Revenue	101,850,666		101,850,666
Routine Revenue	77,265,022		77,265,022
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Included Part I-Hospital Observation Bed days from W/S S-3, Column 8 of the Medicare report
BHF Page 2 - Included the Part I-Hopsital Psych days from W/S S-3 of the Medicare report
BHF Page 2 - Adjusted the I/P Days to agree with W/S S-3 of the Medicare report
BHF Page 2 - Part II-Program days and discharges agree with W/S S-3 of the Medicare report
BHF Page 3 - Adjusted Col 1, Costs and Col 2 Charges to agree with W/S C, Part I, Cols 1 & 8 of the Medicare report
BHF Page 3 - Filed report costs & charges for Clinics and Offsite Clinics have been combined by provider.
BHF Page 4 - Allocated A&P Routine Service Costs between Acute and Psych based upon Inpatient Days.
See attached spreadsheet
BHF Page 4 - Adjusted the Routine costs to agree with W/S C, Part I, Col 1 of the Medicare report
BHF Supplemental 2b - Allocated A&P GME costs between Acute & Psych based upon Inpatient Days
See attached spreadsheet
BHF Supplemental 2a & 2b - Adjusted the GME costs to agree with W/S B, Part I, Col 25 of the Medicare report