# 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:** Harsha Behavioral Center, Inc. | **Medicare Provider Number:** 15-4054 |
| **Street:** 1980 E Woodsmall Dr. | **Medicaid Provider Number:** 20005 |
| **City:** Terre Haute | **State:** Indiana |
| | **Zip:** 47802 |
| **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 |
| [ ] | Other (Specify) | [XXXX] | Corporation | [ ] | County | [ ] | Other (Specify) |

## Type of Hospital

| | | | | | |
|---|---|---|---|---|---|
| [ ] | General Short-Term | [XXXX] | 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)) Harsha Behavioral Center, Inc 20005 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):

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: |
|---|---|
| 15-4054 | 20005 |
| **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 | 81 | 29,565 | | 16,081 | 54.39% | | 2,848 | 5.65 |
| 2. | Psych | | | | | | | | |
| 3. | Rehab | | | | | | | | |
| 4. | Other (Sub) | | | | | | | | |
| 5. | Intensive Care Unit | | | | | | | | |
| 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 | | | | | | | | |
| **22.** | **Total** | **81** | **29,565** | | **16,081** | **54.39%** | | **2,848** | **5.65** |
| 23. | Observation Bed Days | | | | | | | | |

| | **Part II-Program** | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Adults and Pediatrics | | | | 5 | | | 1 | 5.00 |
| 2. | Psych | | | | | | | | |
| 3. | Rehab | | | | | | | | |
| 4. | Other (Sub) | | | | | | | | |
| 5. | Intensive Care Unit | | | | | | | | |
| 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 | | | | | | | | |
| **22.** | **Total** | | | | **5** | **0.03%** | | **1** | **5.00** |

| 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: |
|---|---|
| 15-4054 | 20005 |
| **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 | | | | | | | |
| 2. | Recovery Room | | | | | | | |
| 3. | Delivery and Labor Room | | | | | | | |
| 4. | Anesthesiology | | | | | | | |
| 5. | Radiology - Diagnostic | | | | | | | |
| 6. | Radiology - Therapeutic | | | | | | | |
| 7. | Nuclear Medicine | | | | | | | |
| 8. | Laboratory | 64,711 | 139,755 | 0.463032 | | | | |
| 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 | 116,898 | 9,386 | 12.454507 | | | | |
| 19. | Drugs Charged to Patients | 95,075 | 141,740 | 0.670770 | | | | |
| 20. | Renal Dialysis | | | | | | | |
| 21. | Ambulance | | | | | | | |
| 22. | Group Therapy | 152,422 | 444,360 | 0.343015 | | | | |
| 23. | Individual Therapy | 130,600 | 34,875 | 3.744803 | | | | |
| 24. | All Inclusive Ancillary | | | | | | | |
| 25. | Other | | | | | | | |
| 26. | Other | | | | | | | |
| 27. | Other | | | | | | | |
| 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 | | | | | | | |
| 44. | Emergency | | | | | | | |
| 45. | Observation | | | | | | | |
| **46.** | **Total** | | | | | | | |

* 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: |
|---|---|
| 15-4054 | 20005 |
| **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) | 11,842,819 | | | |
| b) | Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8) | 16,081 | | | |
| c) | Adjusted general inpatient routine service cost per diem (Line 1a / 1b) | 736.45 | | | |
| 2. | Program general inpatient routine days (BHF Page 2, Part II, Col. 4) | 5 | | | |
| 3. | Program general inpatient routine cost (Line 1c X Line 2) | 3,682 | | | |
| 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) | 3,682 | | | |

| 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 | | | | | |
| 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 | | | | | |
| 24. | Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46) | | | | | |
| **25.** | **Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)** | | | | | **3,682** |

## 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: |
|---|---|
| 15-4054 | 20005 |
| **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. | 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: |
|---|---|
| 15-4054 | 20005 |
| **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. | Group Therapy | | | | | | | |
| 23. | Individual Therapy | | | | | | | |
| 24. | All Inclusive Ancillary | | | | | | | |
| 25. | Other | | | | | | | |
| 26. | Other | | | | | | | |
| 27. | Other | | | | | | | |
| 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: |
|---|---|
| 15-4054 | 20005 |
| **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. | 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: |
|---|---|
| 15-4054 | 20005 |
| **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) | 3,682 | |
| 3. | Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b) | | |
| 4. | Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7) | | |
| 5. | Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8) | | |
| 6. | Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69) | | |
| **7.** | **Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)** | **3,682** | |
| 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) | | |
| 10. | Inpatient Routine Services (Provider's Records) | | |
| | A. Adults and Pediatrics | 7,000 | |
| | B. Psych | | |
| | C. Rehab | | |
| | D. Other (Sub) | | |
| | E. Intensive Care Unit | | |
| | 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 | | |
| 11. | Services of Teaching Physicians (Provider's Records) | | |
| **12.** | **Total Charges for Patient Services (Sum of Lines 9 through 11)** | 7,000 | |
| 13. | Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2) | | 3,318 |
| 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: |
|---|---|
| 15-4054 | 20005 |
| **Program:** | **Period Covered by Statement:** |
| Medicaid Hospital | From: 01/01/2023 To: 12/31/2023 |

| 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) | 3,682 | |
| 2. | Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2) | | |
| 3. | Total Current Cost Reporting Period Cost (Line 1 Minus Line 2) | 3,682 | |
| 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)** | **3,682** | |

| 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: |
|---|---|
| 15-4054 | 20005 |
| **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) | 3,318 |
| 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: |
|---|---|
| 15-4054 | 20005 |
| 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<br>(CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3) | |
| 2. | Physicians on medical school faculty average per diem<br>(CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3) | |
| 3. | Total Per Diem<br>(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<br>(BHF Page 2, Part II, Column 4) | | | | |
| 5. | Program outpatient occasions of service<br>(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)<br>(to BHF Page 7, Col. 1, Line 5) | | | | |
| 7. | Program outpatient cost (Line 5 X Line 3)<br>(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<br>(A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29) | | | | |
| 2. | Routine Days | | | | |
| | (A) Semi-private general care days<br>(CMS 2552-10, W/S D - 1, Part I, Line 4) | | | | |
| | (B) Private room days<br>(CMS 2552-10, W/S D - 1, Part I, Line 3) | | | | |
| 3. | Private room charge per diem<br>(1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32) | | | | |
| 4. | Semi-private room charge per diem<br>(1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33) | | | | |
| 5. | Private room charge differential per diem<br>(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)<br>((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27)<br>Divided by (Line 1A Above))** | | | | |
| 7. | Private room cost differential adjustment<br>(Line 2B X Line 6) | | | | |
| 8. | General inpatient routine service cost (net of swing bed and private room cost differential)<br>(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: |
|---|---|
| 15-4054 | 20005 |
| **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 | | | | | | | |
| 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. | Group Therapy | | | | | | | |
| 23. | Individual Therapy | | | | | | | |
| 24. | All Inclusive Ancillary | | | | | | | |
| 25. | Other | | | | | | | |
| 26. | Other | | | | | | | |
| 27. | Other | | | | | | | |
| 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 | | | | | | | |
| 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 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: |
|---|---|
| 15-4054 | 20005 |
| **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 | | | | | | | |
| 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
## Reconciliation of Patient Days and Revenue

**Preliminary**

| Medicare Provider Number: | Medicaid Provider Number: |
|---|---|
| 15-4054 | 20005 |
| **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 | 5 | | 5 |
| Newborn Days | | | |
| Total Inpatient Revenue | 7,000 | | 7,000 |
| Ancillary Revenue | | | |
| Routine Revenue | 7,000 | | 7,000 |
| Inpatient Received and Receivable | | | |
| **Outpatient Reconciliation** | | | |
| Outpatient Occasions of Service | | | |
| Total Outpatient Revenue | | | |
| Outpatient Received and Receivable | | | |

**Notes:**

Preliminary Audit Adjustments:

BHF Page 2 - Part II-Program days agree with the IPCR
BHF Page 3 - IP charges agree with the IPCR
BHF Page 7 - Routine charges agree with the IPCR