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: University of Chicago Medical Center		**Medicare Provider Number:** 14-0088	
Street: 5841 South Maryland Avenue		**Medicaid Provider Number:** 3023	
City: Chicago	**State:** Illinois	**Zip:** 60637-1424	
Period Covered by Statement:	**From:** 07/01/2022	**To:** 06/30/2023	

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)) University of Chicago Medical 3023 for the cost report beginning 07/01/2022 and ending 06/30/2023 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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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	441	160,965		152,886	94.98%		24,246	7.65
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	64	23,360		20,744	88.80%			
6.	Coronary Care Unit	32	11,680		9,336	79.93%			
7.	Burn ICU	8	2,920		2,587	88.60%			
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				4,076				
22.	**Total**	**545**	**198,925**		**189,629**	**95.33%**		**24,246**	**7.65**
23.	Observation Bed Days				20,457				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				7,803			1,395	6.36
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				867				
6.	Coronary Care Unit				98				
7.	Burn ICU				105				
8.	Nursery Special Care								
9.	Nursery ICU								
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				876				
22.	**Total**				**9,749**	**5.14%**		**1,395**	**6.36**

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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	146,606,661	802,165,897	0.182764	14,669,375		2,681,034	
2.	Recovery Room	35,833,069	114,705,304	0.312392				
3.	Delivery and Labor Room	20,743,254	52,459,708	0.395413	1,512,360		598,007	
4.	Anesthesiology	19,266,215	353,226,956	0.054543	6,108,559		333,179	
5.	Radiology - Diagnostic	51,297,421	308,573,395	0.166241	8,960,297		1,489,569	
6.	Radiology - Therapeutic	47,724,490	283,474,309	0.168356	361,708		60,896	
7.	Nuclear Medicine							
8.	Laboratory	96,667,943	##########	0.069661	28,625,585		1,994,087	
9.	Blood							
10.	Blood - Administration	27,981,574	167,261,982	0.167292	5,181,375		866,803	
11.	Intravenous Therapy							
12.	Respiratory Therapy	32,343,610	192,781,828	0.167773	6,382,307		1,070,779	
13.	Physical Therapy	16,126,166	60,770,041	0.265364	1,316,378		349,319	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	25,976,817	244,314,286	0.106325	5,523,301		587,265	
17.	EEG	9,011,011	38,753,413	0.232522	628,184		146,067	
18.	Med. / Surg. Supplies	44,141,293	226,602,261	0.194796	1,766,874		344,180	
19.	Drugs Charged to Patients	325,379,962	##########	0.219072	24,936,497		5,462,888	
20.	Renal Dialysis	8,198,823	50,481,400	0.162413	1,920,291		311,880	
21.	Ambulance	2,503,180	30,499	82.074166				
22.	CT Scan	17,787,396	747,589,055	0.023793	16,479,635		392,100	
23.	MRI	9,917,976	247,019,078	0.040151	2,785,248		111,830	
24.	Cardiac Cath	10,054,379	110,719,036	0.090810	3,695,987		335,633	
25.	Brace & Plaster Room	3,717,819	22,889,547	0.162424	2,513		408	
26.	Implants	68,289,804	326,882,096	0.208913	5,714,897		1,193,916	
27.	Cardiac Rehab	372,682	3,217,279	0.115838				
28.	Kidney Acquisition	17,433,515	20,013,472	0.871089	157,316		137,036	
29.	Heart Acquisition	8,839,296	19,111,940	0.462501	601,324		278,113	
30.	Liver Acquisition	9,654,668	18,550,912	0.520442	413,914		215,418	
31.	Lung Acquisition	1,898,138	752,045	2.523969				
32.	Pancreas Acquisition	1,207,974	1,188,942	1.016008				
33.	All Other Clinics	98,315,099	615,944,510	0.159617	2,948		471	
34.	I&R NATP							
35.	Allogenic Cell	9,711,009	7,153,251	1.357566				
36.	Islet Acquisition							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Service Cost Centers							
43.	Clinic	204,423,900	492,081,635	0.415427	4,206,117		1,747,335	
44.	Emergency	63,653,926	455,551,616	0.139729	7,883,511		1,101,555	
45.	Observation	44,969,559	117,574,692	0.382477				
46.	**Total**				**149,836,501**		**21,809,768**	

* 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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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)	310,202,766			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	173,343			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,789.53			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	7,803			
3.	Program general inpatient routine cost (Line 1c X Line 2)	13,963,703			
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)	13,963,703			

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	73,581,689	20,744	3,547.13	867	3,075,362
9.	Coronary Care Unit	24,680,188	9,336	2,643.55	98	259,068
10.	Burn ICU	8,431,526	2,587	3,259.19	105	342,215
11.	Nursery Special Care					
12.	Nursery ICU					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	4,100,154	4,076	1,005.93	876	881,195
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					21,809,768
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**40,331,311**

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	All Other Clinics							
34.	I&R NATP							
35.	Allogenic Cell							
36.	Islet Acquisition							
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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)	40,331,311	
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)	2,767,818	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**43,099,129**	
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)	149,836,501	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	30,258,578	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	19,706,464	
	F. Coronary Care Unit	3,577,334	
	G. Burn ICU	1,260,706	
	H. Nursery Special Care		
	I. Nursery ICU		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	2,798,784	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	207,438,367	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		164,339,238
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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)	43,099,129	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	43,099,129	
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)**	**43,099,129**	

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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)	164,339,238
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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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	21,947,981	802,165,897	0.027361	14,669,375		401,369	
2.	Recovery Room							
3.	Delivery and Labor Room	2,945,733	52,459,708	0.056152	1,512,360		84,922	
4.	Anesthesiology	10,963,507	353,226,956	0.031038	6,108,559		189,597	
5.	Radiology - Diagnostic	5,545,526	308,573,395	0.017971	8,960,297		161,025	
6.	Radiology - Therapeutic	6,267,108	283,474,309	0.022108	361,708		7,997	
7.	Nuclear Medicine							
8.	Laboratory	3,918,908	##########	0.002824	28,625,585		80,839	
9.	Blood							
10.	Blood - Administration	1,404,726	167,261,982	0.008398	5,181,375		43,513	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	4,006,266	244,314,286	0.016398	5,523,301		90,571	
17.	EEG	4,850,150	38,753,413	0.125154	628,184		78,620	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,256,217	50,481,400	0.024885	1,920,291		47,786	
21.	Ambulance							
22.	CT Scan	496,197	747,589,055	0.000664	16,479,635		10,942	
23.	MRI							
24.	Cardiac Cath							
25.	Brace & Plaster Room							
26.	Implants							
27.	Cardiac Rehab							
28.	Kidney Acquisition							
29.	Heart Acquisition							
30.	Liver Acquisition							
31.	Lung Acquisition							
32.	Pancreas Acquisition							
33.	All Other Clinics							
34.	I&R NATP							
35.	Allogenic Cell							
36.	Islet Acquisition							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	Outpatient Ancillary Centers							
43.	Clinic	12,880,156	492,081,635	0.026175	4,206,117		110,095	
44.	Emergency	7,781,907	455,551,616	0.017082	7,883,511		134,666	
45.	Observation							
46.	**Ancillary Total**						**1,441,942**	

* 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:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

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	21,894,767	173,343	126.31	7,803		985,597	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	3,864,656	20,744	186.30	867		161,522	
52.	Coronary Care Unit	2,904,633	9,336	311.12	98		30,490	
53.	Burn ICU	393,114	2,587	151.96	105		15,956	
54.	Nursery Special Care							
55.	Nursery ICU							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	615,659	4,076	151.04	876		132,311	
67.	**Routine Total (lines 47-66)**						**1,325,876**	
68.	**Ancillary Total (from line 46)**						**1,441,942**	
69.	**Total (Lines 67-68)**						**2,767,818**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0088	3023
Program:	**Period Covered by Statement:**
Medicaid Hospital	From: 07/01/2022 To: 06/30/2023

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	8,873		8,873
Newborn Days	876		876
Total Inpatient Revenue	207,438,366	1	207,438,367
Ancillary Revenue	149,836,500	1	149,836,501
Routine Revenue	57,601,866		57,601,866
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 3 - Adjusted out the I&R NATP and Islet Acquistion Costs as no offsetting Charges
BHF Page 3 - Delivery room contains L&D Triage per W/S C, Part I of the Medicare report
BHF Page 3 - Radiology Diagnostic contains Ultra Sound per the Medicare report
BHF Page 3 - Radiology Therapeutic contains Radioisotope per the Medicare report
BHF Page 3 - Other Clinics contain Transplant, Silver Cross, Orland Park and River East
BHF Page 4 - General I/P Routine Service Costs, ICU Costs, Corornary Care Costs & Nursery Costs allocated between Acute & Childrens per attached worksheet
BHF Supplemental 2b - GME Costs for A&P, ICU, Coronary Care & Nursery allocated between Acute and Children's per attached worksheet

Minor rounding adjustment