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: Kindred Hospital-Chicago		**Medicare Provider Number:**	14-2008
Street: 365 E. North Avenue		**Medicaid Provider Number:**	14085
City: Northlake	**State:** Illinois	**Zip:**	60164
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
	Corporation		Partnership		City		Hospital District
	Other (Specify)	XXXX	Corporation		County		Other (Specify)

Type of Hospital

	General Short-Term		Psychiatric		Cancer
XXXX	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 Punishab 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 Balan Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s Kindred Hospital-Chicago 14085 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 an complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as note

Prepared by (Signed)

Signed (Officer or Administrator of Provider(s))

Name (Typewritten)		Name (Typewritten)	
Title	Date	Title	
Firm		Date	
Telephone Number		Telephone Number	
Email Address		Email Address	

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or befo the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Cente

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-2008	14085
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	155	56,575		32,036	56.63%		1,002	31.97
2.	Psych	30	10,950		5,257	48.01%		606	8.67
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**	**185**	**67,525**		**37,293**	**55.23%**		**1,608**	**23.19**
23.	Observation Bed Days								

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				3,424			85	40.28
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**				**3,424**	**9.18%**		**85**	**40.28**

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:
14-2008	14085
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	2,433,311	3,320,036	0.732917	211,107		154,724	
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic	1,123,477	4,540,051	0.247459	293,258		72,569	
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory	2,979,491	14,956,376	0.199212	1,058,336		210,833	
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy	7,541,635	47,549,490	0.158606	5,836,676		925,732	
13.	Physical Therapy	2,641,727	3,697,674	0.714429	233,678		166,946	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies	118,091	213,780	0.552395	22,884		12,641	
19.	Drugs Charged to Patients	5,305,487	44,406,332	0.119476	4,627,125		552,830	
20.	Renal Dialysis	2,290,102	7,009,969	0.326692	594,021		194,062	
21.	Ambulance							
22.	Other							
23.	Other							
24.	Other							
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**				**12,877,085**		**2,290,337**	

* If Medicare claims billed net of professional component, total hospital professional component charg
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:
14-2008	14085
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 c swing bed and private room cost differential) (see instructions	40,314,849	6,615,530		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	32,036	5,257		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,258.42	1,258.42		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	3,424			
3.	Program general inpatient routine cos (Line 1c X Line 2)	4,308,830			
4.	Average per diem private room cost differentia (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicabl to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicabl to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cos (Line 3 + Line 6)	4,308,830			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1) (A)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8) (B)	Average Per Diem (Col. A / Col. B) (C)	Program Days (BHF Page 2, Part II, Col. 4) (D)	Program Cost (Col. C x Col. 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 cos (BHF Page 3, Col. 6, Line 46)					2,290,337
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**6,599,167**

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:
14-2008	14085
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:
14-2008	14085
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.	Other							
23.	Other							
24.	Other							
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 charg
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:
14-2008	14085
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:
14-2008	14085
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)	6,599,167	
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)**	**6,599,167**	
8.	Ratio of Inpatient and Outpatient Cost to Total Cos (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)	12,877,085	
10.	Inpatient Routine Services (Provider's Records		
	A. Adults and Pediatrics	20,326,264	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Uni		
	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)**	33,203,349	
13.	Excess of Customary Charges Over Reasonable Co (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		26,604,182
14.	Excess of Reasonable Cost Over Customary Charge (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatier (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-2008	14085
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 Service (BHF Page 7, Line 7, Cols. 1 & 2)	6,599,167	
2.	Excess Reasonable Cos (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cos (Line 1 Minus Line 2)	6,599,167	
4.	Recovery of Excess Reasonable Cost Unde 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)**	**6,599,167**	

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:
14-2008	14085
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 Cos (BHF Page 7, Line 13)	26,604,182
2.	Carry Over of Excess Reasonable Cos (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cos (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 Cos (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 Ratio	Inpatient Amount (Col. 1x2A)	Outpatient Ratio	Outpatient 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
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-2008	**Medicaid Provider Number:** 14085
Program: Medicaid Hospital	**Period Covered by Statement:** 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 dien (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2.	Physicians on medical school faculty average per dien (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 servic (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 swin bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
	(B) Routine general care semi-private room charges (Excludin 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 dien (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4.	Semi-private room charge per dien (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5.	Private room charge differential per dien (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 adjustmen (Line 2B X Line 6)				
8.	General inpatient routine service cost (net of swing bed an 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:**
14-2008	**14085**
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							
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.	Other							
23.	Other							
24.	Other							
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 charg
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:
14-2008	14085
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							
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:
14-2008	14085
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	4,171	(747)	3,424
Newborn Days			
Total Inpatient Revenue	37,293,840	(4,090,491)	33,203,349
Ancillary Revenue	12,877,085		12,877,085
Routine Revenue	24,416,755	(4,090,491)	20,326,264
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

The allocation of days for Adults and Peds to Psych Unit came from provider's dat

BHF Page 2 - Split the total beds and bed days in Part I-Hospital between Psych and A&P per numbers on W/S S-3 Part I;
Provider included the split on the Psych report; we carried over to the Acute repo
BHF Page 2 - Adjusted the hospital discharges in Part I-Hospital for Psych and A&P so the combined amount agree
with W/S S-3, Col 15 of the Medicare report
BHF Page 2 - Adjusted the program days and discharges for Psych and A&P so the combined amounts agree wit
W/S S-3, Col 7 and Col 14 of the Medicare report under Title XIX
BHF Page 3 - Agreed col 1 of cost report to W/S C, Part I
BHF Page 4 - Changed line 1a to agree with W/S C Part I, Line 30 Col 1. Then allocated the I/P Operating
Costs based on percentage of patient days between A&P and Psych(see attached allocatior
BHF Page 7 - Based upon the way the Routine Costs are reported on BHF Page 4 of the cost report which included th
Psych portion of the costs in A&P, it seems the Psych charges are included in the A&P on BHF Page 7. So, adjustec
out the Psych portion that's reported on the as-filed Psych cost report from the Acute repo