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 Illinois Hospital & Health Sciences			**Medicare Provider Number:** 14-0150
Street: 1740 W. Taylor Street			**Medicaid Provider Number:** 3098
City: Chicago	**State:** Illinois	**Zip:** 60612	
Period Covered by Statement:	**From:** 07/01/2022	**To:** 06/30/2023	

Type of Control

Voluntary Nonprofit		Proprietary		Government (Non-Federal)			
[ ]	Church	[ ]	Individual	[XXXX]	State	[ ]	Township
[ ]	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)

[ ]	Medicaid Hospital	[ ]	Medicaid Sub II Rehab	[ ]	
[XXXX]	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 Illinois Hospital & 3098 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:
14-0150	3098
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	294	107,310		74,687	69.60%		16,650	6.31
2.	Psych	50	18,250		12,762	69.93%		648	19.69
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	42	15,330		13,769	89.82%			
6.	Coronary Care Unit	19	6,935		6,153	88.72%			
7.	Pediatric ICU	10	3,650		991	27.15%			
8.	Neonatal ICU	30	10,950		9,407	85.91%			
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	25	9,125		2,639	28.92%			
22.	**Total**	**470**	**171,550**		**120,408**	**70.19%**		**17,298**	**6.81**
23.	Observation Bed Days				8,230				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics								
2.	Psych				659			38	17.34
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU								
8.	Neonatal ICU								
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**				**659**	**0.55%**		**38**	**17.34**

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:
14-0150	3098
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	83,524,243	254,812,420	0.327787	3,798		1,245	
2.	Recovery Room	10,911,752	18,605,796	0.586471	4,480		2,627	
3.	Delivery and Labor Room	23,649,489	51,310,880	0.460906				
4.	Anesthesiology	10,507,958	111,744,860	0.094035	14,666		1,379	
5.	Radiology - Diagnostic	17,382,109	67,187,442	0.258711	5,476		1,417	
6.	Radiology - Therapeutic	9,997,656	34,151,965	0.292740				
7.	Nuclear Medicine	2,358,292	9,849,067	0.239443				
8.	Laboratory	64,399,531	598,008,522	0.107690	132,542		14,273	
9.	Blood							
10.	Blood - Administration	10,458,462	50,159,616	0.208504				
11.	Intravenous Therapy	484,764	3,160,311	0.153391	3,549		544	
12.	Respiratory Therapy	8,973,915	78,937,728	0.113683	29,263		3,327	
13.	Physical Therapy	11,300,507	30,931,038	0.365345	2,166		791	
14.	Occupational Therapy	5,505,695	14,129,901	0.389649	55,263		21,533	
15.	Speech Pathology	2,229,972	3,994,573	0.558250				
16.	EKG	630,849	7,789,980	0.080982	9,408		762	
17.	EEG	2,256,548	5,702,226	0.395731	4,363		1,727	
18.	Med. / Surg. Supplies	161,263,019	228,278,634	0.706431				
19.	Drugs Charged to Patients	192,989,798	392,039,902	0.492271	84,622		41,657	
20.	Renal Dialysis	9,849,050	39,594,941	0.248745				
21.	Ambulance							
22.	Ultrasound	3,174,894	21,520,015	0.147532				
23.	Radiology Angiography	7,822,322	74,770,038	0.104618				
24.	Radiology W. Harrison	2,165,349	13,202,673	0.164008				
25.	CT Scan	5,400,173	162,798,478	0.033171	15,830		525	
26.	MRI	6,688,411	102,960,288	0.064961	14,076		914	
27.	Cardiac Catheterization	2,298,498	40,353,228	0.056959				
28.	Lab Tissue Typing	4,717,329	18,210,223	0.259048				
29.	Lab Outreach	13,038,570	170,995,789	0.076251				
30.	Gastroenterology	15,630,169	48,458,201	0.322550				
31.	Bone Marrow Transplant	2,619,146	1,083,982	2.416226				
32.	Cardiac Services	6,717,557	40,514,540	0.165806				
33.	Kidney Acquisition	18,460,343	32,753,820	0.563609				
34.	Liver Acquisition	3,658,764	8,293,614	0.441154				
35.	Pancreas Acquisition	2,036,468	6,747,897	0.301793				
36.	Other Organ Acquisition	478,969	331,724	1.443878				
37.	Radio Mile Square	1,437,557	6,449,115	0.222908				
38.	Telemedicine Prgm							
39.	Sleep Lab West Harr	2,755,233	7,575,647	0.363696				
40.	Sickle Cell Clinic	1,776,401	570,374	3.114449				
41.	Heart Ctr	1,187,735	1,959,114	0.606261				
42.	Hyperbarid Oxygen Ther.	11,994	170,392	0.070391				
	Outpatient Service Cost Centers							
43.	Clinic	107,444,836	233,975,229	0.459215				
44.	Emergency	28,601,641	121,008,201	0.236361	1,218		288	
45.	Observation	14,549,652	31,897,534	0.456137				
46.	**Total**				**380,720**		**93,009**	

* 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:
14-0150	3098
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)	146,587,213	25,291,643		
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	82,917	12,762		
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,767.88	1,981.79		
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)		659		
3.	Program general inpatient routine cost (Line 1c X Line 2)		1,306,000		
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)		1,306,000		

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	37,460,294	13,769	2,720.63		
9.	Coronary Care Unit	19,578,238	6,153	3,181.90		
10.	Pediatric ICU	5,175,401	991	5,222.40		
11.	Neonatal ICU	21,436,421	9,407	2,278.77		
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	2,529,907	2,639	958.66		
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					93,009
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**1,399,009**

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:
14-0150	3098
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.	Pediatric ICU						
9.	Neonatal ICU						
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:
14-0150	3098
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.	Ultrasound							
23.	Radiology Angiography							
24.	Radiology W. Harrison							
25.	CT Scan							
26.	MRI							
27.	Cardiac Catheterization							
28.	Lab Tissue Typing							
29.	Lab Outreach							
30.	Gastroenterology							
31.	Bone Marrow Transplant							
32.	Cardiac Services							
33.	Kidney Acquisition							
34.	Liver Acquisition							
35.	Pancreas Acquisition							
36.	Other Organ Acquisition							
37.	Radio Mile Square							
38.	Telemedicine Prgm							
39.	Sleep Lab West Harr							
40.	Sickle Cell Clinic							
41.	Heart Ctr							
42.	Hyperbarid Oxygen Ther.							
	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:
14-0150	3098
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.	Pediatric ICU							
54.	Neonatal ICU							
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:
14-0150	3098
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)	1,399,009	
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)	65,427	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**1,464,436**	
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)	380,720	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics		
	B. Psych	1,877,491	
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Pediatric ICU		
	H. Neonatal ICU		
	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)**	2,258,211	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		793,775
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:
14-0150	3098
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)	1,464,436	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	1,464,436	
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)**	**1,464,436**	

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:
14-0150	3098
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)	793,775
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:
14-0150	3098
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:
14-0150	3098
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	10,049,277	254,812,420	0.039438	3,798		150	
2.	Recovery Room	125,552	18,605,796	0.006748	4,480		30	
3.	Delivery and Labor Room	1,491,192	51,310,880	0.029062				
4.	Anesthesiology	2,593,686	111,744,860	0.023211	14,666		340	
5.	Radiology - Diagnostic	453,381	67,187,442	0.006748	5,476		37	
6.	Radiology - Therapeutic	2,584,672	34,151,965	0.075682				
7.	Nuclear Medicine	323,753	9,849,067	0.032871				
8.	Laboratory	11,748,360	598,008,522	0.019646	132,542		2,604	
9.	Blood							
10.	Blood - Administration	1,895,089	50,159,616	0.037781				
11.	Intravenous Therapy	21,326	3,160,311	0.006748	3,549		24	
12.	Respiratory Therapy	2,217,929	78,937,728	0.028097	29,263		822	
13.	Physical Therapy	562,498	30,931,038	0.018186	2,166		39	
14.	Occupational Therapy	281,884	14,129,901	0.019949	55,263		1,102	
15.	Speech Pathology	207,059	3,994,573	0.051835				
16.	EKG	580,014	7,789,980	0.074456	9,408		700	
17.	EEG	38,479	5,702,226	0.006748	4,363		29	
18.	Med. / Surg. Supplies	3,772,425	228,278,634	0.016526				
19.	Drugs Charged to Patients	12,840,652	392,039,902	0.032753	84,622		2,772	
20.	Renal Dialysis	1,354,242	39,594,941	0.034202				
21.	Ambulance							
22.	Ultrasound	383,211	21,520,015	0.017807				
23.	Radiology Angiography	2,414,935	74,770,038	0.032298				
24.	Radiology W. Harrison	89,092	13,202,673	0.006748				
25.	CT Scan	2,211,349	162,798,478	0.013583	15,830		215	
26.	MRI	1,781,831	102,960,288	0.017306	14,076		244	
27.	Cardiac Catheterization	2,613,654	40,353,228	0.064769				
28.	Lab Tissue Typing	122,883	18,210,223	0.006748				
29.	Lab Outreach	1,153,880	170,995,789	0.006748				
30.	Gastroenterology	326,996	48,458,201	0.006748				
31.	Bone Marrow Transplant	7,315	1,083,982	0.006748				
32.	Cardiac Services	273,392	40,514,540	0.006748				
33.	Kidney Acquisition	529,772	32,753,820	0.016174				
34.	Liver Acquisition	338,985	8,293,614	0.040873				
35.	Pancreas Acquisition	45,535	6,747,897	0.006748				
36.	Other Organ Acquisition	66,561	331,724	0.200652				
37.	Radio Mile Square	43,519	6,449,115	0.006748				
38.	Telemedicine Prgm							
39.	Sleep Lab West Harr	51,120	7,575,647	0.006748				
40.	Sickle Cell Clinic	3,849	570,374	0.006748				
41.	Heart Ctr	13,220	1,959,114	0.006748				
42.	Hyperbarid Oxygen Ther.	1,150	170,392	0.006749				
	Outpatient Ancillary Centers							
43.	Clinic	4,891,489	233,975,229	0.020906				
44.	Emergency	2,688,357	121,008,201	0.022216	1,218		27	
45.	Observation							
46.	**Ancillary Total**						**9,135**	

* 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:
14-0150	3098
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	8,047,074	82,917	97.05				
48.	Psych	1,090,076	12,762	85.42	659		56,292	
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	1,577,514	13,769	114.57				
52.	Coronary Care Unit	1,157,869	6,153	188.18				
53.	Pediatric ICU	589,744	991	595.10				
54.	Neonatal ICU	2,206,268	9,407	234.53				
55.	Other							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery	172,389	2,639	65.32				
67.	**Routine Total (lines 47-66)**						**56,292**	
68.	**Ancillary Total (from line 46)**						**9,135**	
69.	**Total (Lines 67-68)**						**65,427**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0150	3098
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	659		659
Newborn Days			
Total Inpatient Revenue	2,258,211		2,258,211
Ancillary Revenue	380,720		380,720
Routine Revenue	1,877,491		1,877,491
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

BHF Page 2 - Removed L&D days and beds from Part I-Hospital & Part II-Program
BHF Page 2 - Part I-Hopsital Nursery Bed Days adjusted to a 365 day reporting period
BHF Page 3 - Reclassified Blood costs/charges to Blood Admin costs/charges
BHF Page 3 - Clinic costs and charges include Medicare lines 90, 93.01, 93.02, 93.03, 93.04, 93.05 and 76.08.
BHF Page 3 - Physical Therapy costs and charges include Medicare lines 66, 66.01, 66.02, 66.03
BHF Page 3 - Occupational Therapy costs and charges include Medicare lines 67 and 67.01
BHF Page 3 - Adjusted the Total Costs to agree with W/S C, Part I, Col 1 of the Medicare report; Provider reported amounts from W/S B, Part I, Col 24 of the Medicare report instead
BHF Page 4 - Adjusted Routine costs to agree with W/S C, Part I, Col 1 of the Medicare report
BHF Supplemental 2a & 2b - GME costs included from W/S B, Part I, Col 25; $25,320 of stepdown costs in Renal Dialysis not included