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: Rush University Children's Hospital		**Medicare Provider Number:** 14-0119
Street: 1653 W Congress Pkwy		**Medicaid Provider Number:** 3047
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		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)) Rush University Children's Ho 3047 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):

Signed (Officer or Administrator of Provider(s)):

Name (Typewritten)
Title
Date
Firm
Telephone Number
Email Address

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:
14-0119	3047
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	20	7,144		3,670	51.37%		2,274	9.47
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU	18	6,563		3,934	59.94%			
8.	Premature ICU	60	21,900		13,927	63.59%			
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				746				
22.	**Total**	**98**	**35,607**		**22,277**	**62.56%**		**2,274**	**9.47**
23.	Observation Bed Days				1,139				

	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				212			419	5.53
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit								
6.	Coronary Care Unit								
7.	Pediatric ICU				362				
8.	Premature ICU				1,744				
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				139				
22.	**Total**				**2,457**	**11.03%**		**419**	**5.53**

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:
14-0119	3047
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	70,331,502	444,033,062	0.158392	507,318		80,355	
2.	Recovery Room	16,988,396	64,013,479	0.265388	29,913		7,939	
3.	Delivery and Labor Room	12,825,849	21,131,563	0.606952				
4.	Anesthesiology	14,134,267	181,363,522	0.077933	175,491		13,677	
5.	Radiology - Diagnostic	61,099,700	490,172,640	0.124649	578,756		72,141	
6.	Radiology - Therapeutic	12,195,448	113,374,285	0.107568	932		100	
7.	Nuclear Medicine	9,549,715	46,142,702	0.206960	1,187		246	
8.	Laboratory	106,317,085	552,344,990	0.192483	1,468,768		282,713	
9.	Blood							
10.	Blood - Administration	16,182,399	41,789,426	0.387237	458,987		177,737	
11.	Intravenous Therapy							
12.	Respiratory Therapy	19,220,993	52,457,326	0.366412	2,381,575		872,638	
13.	Physical Therapy	6,642,210	16,861,936	0.393917	78,745		31,019	
14.	Occupational Therapy	6,190,783	14,610,370	0.423725	7,781		3,297	
15.	Speech Pathology	3,230,168	6,752,108	0.478394	115,259		55,139	
16.	EKG	17,853,673	131,048,757	0.136237	355,271		48,401	
17.	EEG	3,338,953	14,751,531	0.226346	271,592		61,474	
18.	Med. / Surg. Supplies	57,297,040	178,159,217	0.321606	92,046		29,603	
19.	Drugs Charged to Patients	273,004,487	##########	0.272826	1,527,113		416,636	
20.	Renal Dialysis	6,265,557	18,336,962	0.341690				
21.	Ambulance							
22.	Lab-HLA	2,615,221	5,954,432	0.439206				
23.	Implantable Devices	93,121,937	272,283,634	0.342003				
24.	Kidney Acquisitions	10,396,583	17,557,000	0.592162				
25.	Liver Acquisitions	4,908,881	4,508,000	1.088927				
26.	Pancreas Acquisitions	595,221	504,000	1.180994				
27.	Psych Day Hospital	4,815,200	2,351,476	2.047735				
28.	Allogenic Stem Cell Acq	3,707,672	4,277,931	0.866697				
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	169,796,640	344,432,892	0.492975				
44.	Emergency	34,056,172	206,040,662	0.165289	27,922		4,615	
45.	Observation	17,503,198	108,185,746	0.161788	25,759		4,167	
46.	**Total**				**8,104,415**		**2,161,897**	

* 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:
14-0119	3047
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)	6,689,921			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	4,809			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,391.13			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	212			
3.	Program general inpatient routine cost (Line 1c X Line 2)	294,920			
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)	294,920			

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.	Pediatric ICU	9,916,197	3,934	2,520.64	362	912,472
11.	Premature ICU	25,074,594	13,927	1,800.43	1,744	3,139,950
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	702,370	746	941.51	139	130,870
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					2,161,897
25.	**Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)**					**6,640,109**

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:
14-0119	3047
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.	Premature 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:
14-0119	3047
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.	Lab-HLA							
23.	Implantable Devices							
24.	Kidney Acquisitions							
25.	Liver Acquisitions							
26.	Pancreas Acquisitions							
27.	Psych Day Hospital							
28.	Allogenic Stem Cell Acq							
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:
14-0119	3047
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.	Premature 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:
14-0119	3047
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)	6,640,109	
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)	255,089	
7.	**Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)**	**6,895,198**	
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)	8,104,415	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	276,906	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Pediatric ICU	1,325,265	
	H. Premature ICU	8,880,702	
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	206,659	
11.	Services of Teaching Physicians (Provider's Records)		
12.	**Total Charges for Patient Services (Sum of Lines 9 through 11)**	18,793,947	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		11,898,749
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:
14-0119	3047
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)	6,895,198	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	6,895,198	
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)**	**6,895,198**	

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:
14-0119	3047
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)	11,898,749
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
Teaching Physicians / Routine Services Questionnaire

BHF Supplement No. 1

Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0119	3047
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:
14-0119	3047
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	6,564,654	444,033,062	0.014784	507,318		7,500	
2.	Recovery Room							
3.	Delivery and Labor Room	802,825	21,131,563	0.037992				
4.	Anesthesiology	7,791,491	181,363,522	0.042961	175,491		7,539	
5.	Radiology - Diagnostic	9,005,414	490,172,640	0.018372	578,756		10,633	
6.	Radiology - Therapeutic	544,543	113,374,285	0.004803	932		4	
7.	Nuclear Medicine	1,058,954	46,142,702	0.022950	1,187		27	
8.	Laboratory	2,298,705	552,344,990	0.004162	1,468,768		6,113	
9.	Blood							
10.	Blood - Administration	402,488	41,789,426	0.009631	458,987		4,421	
11.	Intravenous Therapy							
12.	Respiratory Therapy	574,676	52,457,326	0.010955	2,381,575		26,090	
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	1,026,669	131,048,757	0.007834	355,271		2,783	
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	1,446,376	18,336,962	0.078878				
21.	Ambulance							
22.	Lab-HLA							
23.	Implantable Devices							
24.	Kidney Acquisitions	215,235	17,557,000	0.012259				
25.	Liver Acquisitions							
26.	Pancreas Acquisitions							
27.	Psych Day Hospital	3,325,374	2,351,476	1.414165				
28.	Allogenic Stem Cell Acq							
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	11,850,814	344,432,892	0.034407				
44.	Emergency	6,624,919	206,040,662	0.032153	27,922		898	
45.	Observation							
46.	**Ancillary Total**						**66,008**	

* 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:
14-0119	3047
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	1,005,952	4,809	209.18	212		44,346	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Pediatric ICU							
54.	Premature ICU	1,155,809	13,927	82.99	1,744		144,735	
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)**						**189,081**	
68.	**Ancillary Total (from line 46)**						**66,008**	
69.	**Total (Lines 67-68)**						**255,089**	

Hospital Statement of Cost
Reconciliation of Patient Days and Revenue

Preliminary

Medicare Provider Number:	Medicaid Provider Number:	
14-0119	3047	
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	2,318		2,318
Newborn Days	139		139
Total Inpatient Revenue	18,793,946	1	18,793,947
Ancillary Revenue	8,104,414	1	8,104,415
Routine Revenue	10,689,532		10,689,532
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

Notes:

Preliminary Audit Adjustments:

Grouped Ped ICU, Prem ICU, SICU, and MICU accordingly based on adult / children's report per provider's records

BHF Page 2 - Part I-Hospital Nursery days are less than the Part II-Program Nursery days. Based upon the information included in the as-filed cost report, the hospital allocates 81% of the Nursery Costs on W/S C, Part I, Line 43 of the Medicare report to the Adult cost report and 19% of the Costs to the Children's cost report. So, the I/P Nursery days from W/S S-3, Col 8, Line 13 are allocated to the Adult and Children's cost reports based upon the percentages used for allocating the Nursery Costs to the Adult and Children's cost reports

BHF Page 2 - Part II-Program days agree with the IPCR dated 09/15/2023

BHF Page 3 - Reclassified Blood to Blood-Admin to be covered by IL Medicaid

BHF Page 3 - Combined the IV Therapy costs/charges with Labs costs/charges; I/P IV Therapy charges are greater than the total IV Therapy charges for the hospital

BHF Page 3 - I/P Charges agree with the IPCR dated 09/15/2023

BHF Page 3 - I/P OR Charges also contain GI charges per the IPCR

BHF Page 3 - I/P Radiology-Diagnostic Charges also contain CT Scan and MRI charges per the IPCR

BHF Page 3 - I/P EKG Charges also contain Cardiac Cath Lab charges per the IPCR

BHF Page 4 - Spread costs from W/S C, Col. 1 between Adult & Children's Hospital for A&P and Nursery See excel spreadsheet

BHF Page 7 - Total Routine Charges agree with the IPCR dated 09/15/2023

BHF Supplemental 2b - Spread GME costs from W/S B, Column 25 between Acute & Children's Hospital for Adults & Peds; see attached spreadsheet

Minor rounding adjustment