General Information	Preliminary				
Name of Hospital: Methodist Hospital of Chica	ago	Medicare Provider Number: 14-0197			
Street: 5025 N Paulina St		Medicaid Provider Number: 3020			
City:	State:	Zip:			
Chicago Period Covered by Statement:	Illinois From:	60640			
•	07/01/2022	06/30/2023			
Type of Control					
Voluntary Nonprofit	Proprietary Gove	ernment (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	ed 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)) Methodist Hospital of Chicago 3020 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	Name (Typewritten) Title			
Firm Telephone Number		Date 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 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.

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Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

					Total	Percent		Number Of	Average
					Inpatient	Of	Number	Discharges	Length Of
			Total	Total	Days	Occupancy	Of	Including	Stay By
	Inpatient Statistics	Total	Bed	Private	Including	(Column 4	Admissions	Deaths	Program
Line		Beds	Days	Room	Private	Divided By	Excluding	Excluding	Excluding
No.		Available	Available	Days	Room Days	Column 2)	Newborn	Newborn	Newborn
	Part I-Hospital	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	74	27,010	` ′	2,817	10.43%	` ′	1,021	2.79
2.	Psych	62	22,630		11,730	51.83%		1,631	7.19
3.	Rehab								
	Other (Sub)								
5.	Intensive Care Unit	9	3,285		32	0.97%			
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	145	52,925		14,579	27.55%		2,652	5.50
23.	Observation Bed Days				900				
	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				57			21	2.71
2.	Psych								
	Rehab								
	Other (Sub)								
	Intensive Care Unit								
	Coronary Care Unit								
7.	Other								
8.	Other								
9.	Other								
10.	Other								
11.	Other								
12.	Other								
1.7									
13.	Other								
14.	Other Other								
14. 16.	Other Other Other								
14. 16. 17.	Other Other Other Other Other								
14. 16. 17. 18.	Other Other Other Other Other Other								
14. 16. 17. 18. 19.	Other Other Other Other Other Other Other Other								
14. 16. 17. 18. 19.	Other Other Other Other Other Other Other Other Other								
14. 16. 17. 18. 19. 20.	Other Other Other Other Other Other Other Other				57	0.39%		21	2.71

Lin			
No	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
	. Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

BHF Page 3

Preliminar

1 i Cililliai y				
Medicare Provider Number:		Medicaid Provider Number:		
	14-0197	3020		
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) (1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2) (3)	Total Billed I/P Charges (Gross) for Health Care Program Patients (4)	Total Billed O/P Charges (Gross) for Health Care Program Patients (5)	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.	Operating Room	4,841,032	2,232,540	2.168397	` ′	, ,	` '	` '
	Recovery Room	184,832	588,690	0.313972				
	Delivery and Labor Room	,	, , , , , , , , , , , , , , , , , , , ,					
	Anesthesiology	30,427	433,320	0.070218				
	Radiology - Diagnostic	842,408	811,672	1.037868	194		201	
	Radiology - Therapeutic	0.12,100	011,012	1.007 000	101		201	
	Nuclear Medicine							
		1,237,581	2,020,662	0.612463	13,405		8,210	
	Laboratory Blood	1,231,301	2,020,002	0.012403	13,403		0,210	
	Blood - Administration							
	Intravenous Therapy	057.000	705 700	0.000750	0.000		4.407	
	Respiratory Therapy	257,638	795,789	0.323752	3,666		1,187	
13.	Physical Therapy							
	Occupational Therapy							
	Speech Pathology							
	EKG	53,644	147,719	0.363149				
	EEG							
	Med. / Surg. Supplies	711,819	709,114	1.003815	399		401	
	Drugs Charged to Patients	1,163,598	1,523,766	0.763633	2,051		1,566	
	Renal Dialysis							
	Ambulance							
22.	Partial Hospitalization							
	Other							
	Other							
	Other							
	Other							
27.	Other							
28.	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
36.	Other							
	Other							
38.	Other							
39.	Other							
	Other							
	Other							
	Other							
	Outpatient Service Cost Centers							
43.	Clinic							
44.	Emergency	1,200,175	1,624,061	0.738996	554		409	
	Observation	488,970	1,253,237	0.390166				
46.	Total				20,269		11,974	

^{*} 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

BHF Page 4

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Medicare Provider Number:	Medicaid Provider Number:	
14-0197	3020	
Program:	Period Covered by Statement:	
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023	

Program Inpatient Operating Cost

Line		Adults and	Sub I	Sub II	Sub III
No.	Description	Pediatrics	Psych	Rehab	Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of				
	swing bed and private room cost differential) (see instructions)	2,019,437	6,372,881		
b)	Total inpatient days including private room days				
	(CMS 2552-10, W/S S-3, Part 1, Col. 8)	3,717	11,730		
c)	Adjusted general inpatient routine service				
	cost per diem (Line 1a / 1b)	543.30	543.30		
2.	Program general inpatient routine days				
	(BHF Page 2, Part II, Col. 4)	57			
3.	Program general inpatient routine cost				
	(Line 1c X Line 2)	30,968			
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)	30,968			

		Total Dept. Costs	Total Days (CMS 2552-10,	Average	Program Days	
Line	.	(CMS 2552-10,	W/S S-3,	Per Diem	(BHF Page 2,	Program Cost
No.	Description	W/S C, Pt. 1, Col. 1)		(Col. A / Col. B)	Part II, Col. 4)	(Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	143,583	32	4,486.97		
9.	Coronary Care Unit					
10.	Other					
11.	Other					
12.	Other					
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
	Other					
21.	Other					
22.	Other					
	Nursery					
24.	Program inpatient ancillary care service cost					
	(BHF Page 3, Col. 6, Line 46)					11,974
25.	Total Program Inpatient Operating Costs					
	(Sum of Lines 7 through 24)					42,942

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:
14-0197	3020
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) (5)	Program Inpatient Expenses (Col. 4 X Col. 5) (6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics						
	(General Service Care)						
	Psych						
	Rehab						
	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Other						
9.	Other						
10.	Other						
11.	Other						
	Other						
13.	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	Other						
	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)	(BHF I	Charges Page 3, ines 43-45)	•	Expenses Cols. 5A-B)
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
	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

BHF Page 6(a)

1 Tenininai y	
Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

Cost Centers			1		T				
Component Component Component Coharges Charges			l				· -		Outpatient
Cost Centers						_	_	_	_
Line Cost Centers Cost. 4 Cost. 5 Cost. 2 Cost. 4 Cost. 5 Cost. 3 Cost.				•		_	_		•
No.			'	,	_	•			
Impatient Ancillary Cost Centers 10 (2) (3) (4) (5) (6) (7)	Line	Cost Centers	W/S A-8-2,	Pt. 1,	(Col. 1 /	Page 3,	Page 3,		(Col. 3 X
1. (Derating Room 2. Recovery Room 3. Delivery and Labor Room 4. Annestherisology 5. Radiology - Diagnostic 6. Radiology - Therapeutic 7. Nuclear Medicine 8. Laboratory 9. Blood 10. Blood - Administration 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 19. Drugs Charged to Patients 19. Drugs Charged to Patients 20. Renal Diaysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 39. Other 40. Other 41. Other 42. Other 43. Other 44. Other 45. Other 46. Other 47. Other 48. Other 49. Other 49. Other 40. Other 40. Other 41. Other 41. Other 42. Other			Col. 4)	Col. 8)*		Col. 4)	Col. 5)	Col. 4)	Col. 5)
2. Recovery Room 3. Delivery and Labor Room 4. Anesthesiology 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 19. Drugs Charged to Patients 19. Drugs Charged to Patients 20. Rena Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 39. Other 30. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Ot			(1)	(2)	(3)	(4)	(5)	(6)	(7)
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 14. Occupational Therapy 15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 39. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other									
4. Anesthesiology	2.	Recovery Room							
S. Radiology - Diagnostic S. Radiology - Therapeutic S. Radiology -									
B. Radiology - Therapeutic									
7. Nuclear Medicine									
Blood Slood Sloo									
9. Blood									
10. Blood - Administration									
11. Intravenous Therapy									
12, Respiratory Therapy									
13. Physical Therapy									
14. Occupational Therapy									
15. Speech Pathology	13.	Physical Therapy							
16. EKG	14.	Occupational Therapy							
17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. 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 41. Other 44. Emergency 44. Emergency 44. Emergency 45. Observation 45. Observation 46. Observation 47. Other 48. Other 49. Other 40. Other 40. Other 41. Other 44. Emergency 45. Observation	15.	Speech Pathology							
18. Med. / Surg. Supplies									
19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 39. Other 39. Other 30. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 38. Other 39. Other 40. Other 41. Other 41. Other 42. Other 43. Clinic 44. Emergency 44. Emergency 45. Observation									
20. Renal Dialysis	18.	Med. / Surg. Supplies							
21. Ambulance	19.	Drugs Charged to Patients							
22. Partial Hospitalization	20.	Renal Dialysis							
23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 42. Other 44. Emergency 45. Observation									
24. Other 25. Other 26. Other 27. Other 27. Other 28. Other 29. Other 29. Other 30. Other 29. Other 31. Other 29. Other 32. Other 29. Other 33. Other 29. Other 34. Other 29. Other 35. Other 29. Other 36. Other 29. Other 37. Other 29. Other 38. Other 29. Other 39. Other 29. Other 40. Other 29. Other 41. Other 29. Other 42. Other 29. Other 43. Clinic 29. Other 44. Emergency 29. Other 45. Observation 29. Other	22.	Partial Hospitalization							
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 44. Emergency 45. Observation									
26. Other 27. Other 27. Other 28. Other 28. Other 29. Other 30. Other 29. Other 31. Other 29. Other 32. Other 29. Other 33. Other 29. Other 34. Other 29. Other 35. Other 29. Other 36. Other 29. Other 37. Other 29. Other 38. Other 29. Other 39. Other 29. Other 40. Other 29. Other 41. Other 29. Other 42. Other 39. Other 41. Other 39. Other 42. Other 39. Other 43. Other 39. Other 44. Emergency 49. Other 45. Observation 45. Observation									
27. Other 28. Other 29. Other									
28. Other 9. Other 30. Other 9. Other 31. Other 9. Other 32. Other 9. Other 33. Other 9. Other 34. Other 9. Other 35. Other 9. Other 36. Other 9. Other 37. Other 9. Other 38. Other 9. Other 39. Other 9. Other 40. Other 9. Other 41. Other 9. Other 42. Other 9. Other 43. Clinic 9. Other 44. Emergency 9. Other 45. Observation 9. Other									
29. Other 30. Other 31. Other 31. Other 32. Other 32. Other 33. Other 33. Other 34. Other 35. Other 35. Other 36. Other 37. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
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 43. Clinic 44. Emergency 45. Observation									
31. Other 32. Other 32. Other 33. Other 34. Other 34. Other 35. Other 36. Other 37. Other 37. Other 38. Other 39. Other 40. Other 39. Other 41. Other 41. Other 42. Other 42. Other 43. Clinic 44. Emergency 45. Observation 45. Observation									
32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
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									
34. Other									
35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other 43. Clinic 44. Emergency 45. Observation									
37. Other									
38. Other									
39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
40. Other 41. Other 42. Other Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
41. Other									
42. Other Outpatient Ancillary Cost Centers 43. Clinic Outpatient Ancillary Cost Centers 44. Emergency Observation									
Outpatient Ancillary Cost Centers 43. Clinic 44. Emergency 45. Observation									
43. Clinic	42.								
44. Emergency									
45. Observation									
46. Ancillary Total									
	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

BHF Page 6(b)

Fremmary		
Medicare Provider Number:	Medicaid Provider Number:	
14-0197	3020	
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)
	Adults and Pediatrics							
48.	Psych							
	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							
	Other							
65.	Other							
	Nursery							
	Routine Total (lines 47-66)							
68.	Ancillary Total (from line 46)							
69.	Total (Lines 67-68)							

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Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
	Annillant Comings	(1)	(2)
	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
	Inpatient Operating Services		
	(BHF Page 4, Line 25)	42,942	
3.	Interns and Residents Not in an Approved Teaching		
	Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
	Hospital Based Physician Services		
	(BHF Page 6, Line 69, Cols. 6 & 7)		
	Services of Teaching Physicians		
	(BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
	Graduate Medical Education		
	(BHF Supplement No. 2, Cols. 6 and 7, Line 69)		
	Total Reasonable Cost of Covered Services		
	(Sum of Lines 1 through 6)	42,942	
	Ratio of Inpatient and Outpatient Cost to Total Cost		
	(Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line	Customary Charges	Program Inpatient	Program Outpatient
No.		(1)	(2)
9.	Ancillary Services		
	(See Instructions)	20,269	
10.	Inpatient Routine Services		
	(Provider's Records)		
	A. Adults and Pediatrics	64,224	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit		
	F. Coronary Care Unit		
	G. Other		
	H. Other		
	I. Other		
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery		
11.	Services of Teaching Physicians		
	(Provider's Records)		
12.	Total Charges for Patient Services		
	(Sum of Lines 9 through 11)	84,493	
13.	Excess of Customary Charges Over Reasonable Cost	5 1, 100	
	(Line 12 Minus Line 7, Sum of Cols. 1 through 2)		41,551
14	Excess of Reasonable Cost Over Customary Charges	——————————————————————————————————————	11,001
l '''	(Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15	Excess Reasonable Cost Applicable to Inpatient and Outpatient		
'5.	(Line 8, Each Column X Line 14)		

1 reminury		
Medicare Provider Number:	Medicaid Provider Number:	
14-0197	3020	
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)	42,942	
2.	Excess Reasonable Cost		
	(BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost		
	(Line 1 Minus Line 2)	42,942	
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)	42,942	

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)		
	Balance Due Provider / (State Agency) *		
	(Line 6 Minus Line 8)		

 $^{^{\}star}$ Line 9 DOES NOT APPLY to the Medicaid program.

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Preliminary

Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
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	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed			
No.	Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)			
1.	Excess of Customary Charges Over Reasonable Cost			
	(BHF Page 7, Line 13)	41,551		
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

		Prior	Cost Reporting Period	Current Cost Sum of		
Line No.	Description	to	to	to	Reporting Period	Columns 1 - 4
		(1)	(2)	(3)	(4)	(5)
	Carry Over - Beginning of Current Period					
	Recovery of Excess Reasonable Cost (Part I, Line 3)					
	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
	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

		Total (Part II,	In	patient	Out	tpatient
Line	Description	Cols. 1-3,		Amount		Amount
No.		Line 2)	Ratio	(Col. 1x2A)	Ratio	(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)					

Tremmary	
Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
Program:	Period Covered by Statement:
Modicaid-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

	Tart A. Cost of Frysicians Direct medical and Cargical Cervices	
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.	B. Total Per Diem	
	(Line 1 Plus Line 2)	

	General	Sub I	Sub II	Sub III
Part B. Program Data	Service	Psych	Rehab	Other (Sub)
Program inpatient days				
(BHF Page 2, Part II, Column 4)				
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)				
ı	(to BHF Page 7, Col. 2, Line 5)				

Part II - Routine Services Questionnaire

1.	Gross Routine Revenues	Adults and	Sub I	Sub II	Sub III
1 1		Pediatrics	Psych	Rehab	Other (Sub)
	(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)				

Preliminary

1 Tellimiar y	
Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
Program:	Period Covered by Statement:
Medicaid-Hospital	From: 07/01/2022 To: 06/30/2023

1. Operating Room	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Charges (BHF Page 3, Col. 4) (4)	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Cost Centers Inpatient Ancillary Centers	Line No.
2. Recovery Room	 	,=,	,-,	` '	,-,	` ′	` '		
3. Delivery and Labor Room								Recovery Room	2.
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. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other								Delivery and Labor Room	3.
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. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 39. Other 31. Other 31. Other 32. Other 35. Other 36. Other 37. Other 38. Other 39. Other									
7. Nuclear Medicine								Radiology - Diagnostic	5.
B. 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 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Cha								Radiology - Therapeutic	6.
9. Blood 10. Blood - Administration 11. Intravenous Therapy 12. Respiratory Therapy 13. Physical Therapy 14. Occupational Therapy 15. Speech Pathology 16. EKG 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 19. Drugs Charged to Patients								Nuclear Medicine	7.
10. Blood - Administration								Laboratory	8.
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 19. Drugs Charged								Blood	9.
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 19. Drugs									
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. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 39. Other 39. Other 39. Other 39. Other								Intravenous Therapy	11.
14. Occupational Therapy 15. Speech Pathology 16. EKG Seech Pathology 17. EEG Seech Pathology 18. Med. / Surg. Supplies Seech Pathology 19. Drugs Charged to Patients Seech Pathology 20. Renal Dialysis Seech Pathology 21. Ambulance Seech Pathology 22. Partial Hospitalization Seech Pathology 23. Other Seech Pathology 24. Other Seech Pathology 25. Other Seech Pathology 26. Other Seech Pathology 27. Other Seech Pathology 28. Other Seech Pathology 30. Other Seech Pathology 31. Other Seech Pathology 32. Other Seech Pathology 33. Other Seech Pathology 34. Other Seech Pathology 35. Other Seech Pathology 36. Other Seech Pathology 37. Other Seech Pathology 38. Other Seech Pathology 39. Other Seech Pathology 40. Other Seech Pathology 41. Other Seech Pathology								Respiratory Therapy	12.
15. Speech Pathology 16. EKG 17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 30. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 30. Other 30. Other 31. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other								Physical Therapy	13.
16. EKG 17. EEG 17. EEG								Occupational Therapy	14.
17. EEG 18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 25. Other 26. Other 27. Other 28. Other 29. Other 29. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 30. Other 31. Other 32. Other 33. Other 34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 39. Other 30. Other 30. Other								Speech Pathology	15.
18. Med. / Surg. Supplies 19. Drugs Charged to Patients 20. Renal Dialysis									
19. Drugs Charged to Patients 20. Renal Dialysis 21. Ambulance 22. Partial Hospitalization 23. Other 24. Other 24. Other 25. Other 25. Other 26. Other 27. Other 27. Other 28. Other 29. Other 30. Other 30. Other 31. Other 31. Other 33. Other 33. Other 34. Other 35. Other 35. Other 36. Other 37. Other 37. Other 38. Other 39. Other 40. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers 0									
20. Renal Dialysis									
21. Ambulance 22. Partial Hospitalization 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 39. Other 40. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers									
22. Partial Hospitalization 23. Other 24. 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									
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									
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 Outpatient Ancillary Centers									
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 40. Other 41. Other Outpatient Ancillary Centers									
28. Other 9. Other 30. Other 9. Other 31. Other 9. Other 32. Other 9. Other 33. Other 9. Other 35. Other 9. Other 36. Other 9. Other 37. Other 9. Other 38. Other 9. Other 39. Other 9. Other 40. Other 9. Other 41. Other 9. Other 42. Other 9. Other Outpatient Ancillary Centers 9. 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 Outpatient Ancillary Centers									
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	_								
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	_							Other	30.
33. Other	_								
34. Other 35. Other 36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers	+	-	_						
35. Other	+	-							
36. Other 37. Other 38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers	-	-							
37. Other	+	+	 				+		
38. Other 39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers	+	+	 	1			+		
39. Other 40. Other 41. Other 42. Other Outpatient Ancillary Centers	+								
40. Other 41. Other 42. Other Outpatient Ancillary Centers	+	+	 	<u> </u>					
41. Other 42. Other Outpatient Ancillary Centers	+	+							
42. Other Outpatient Ancillary Centers	+								
Outpatient Ancillary Centers	+	†	 						
								Outpatient Ancillary Centers	
43. Clinic									43
44. Emergency	1	1	i						
45. Observation	1								
46. Ancillary Total	1								

^{*} 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 Preliminary

BHF Supplement No. 2(b)

Freniniary	
Medicare Provider Number:	Medicaid Provider Number:
14-0197	3020
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)	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)
	Adults and Pediatrics							
	Psych							
	Rehab							
	Other (Sub)							
	Intensive Care Unit							
	Coronary Care Unit							
	Other							
	Other							
	Other							
	Other							
	Other							
	Other							
59.	Other							
60.	Other							
61.	Other							
	Other							
	Other							
	Other							
	Other							
	Nursery							
	Routine Total (lines 47-66)							
	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:							
14-0197	3020							
Program:	Period Covered by Statement:							
Modicaid-Hospital	From: 07/01/2022 To: 06/30/2023							

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report					
Adult Days	57		57					
Newborn Days								
Total Inpatient Revenue	84,493		84,493					
Ancillary Revenue	20,269		20,269					
Routine Revenue	64,224		64,224					
Inpatient Received and Receivable								
Outpatient Reconciliation								
Outpatient Occasions of Service								
Total Outpatient Revenue								
Outpatient Received and Receivable								
Notes:								
Preliminary Audit Adjustments:								
BHF Page 2 - Included the Psych beds and days stats in Part I								
BHF Page 2 - Added Observation Bed days in Part I-Hospital to BHF Page 2 - Part II-Program days agree with the IPCR	o agree with W/S S-3, Col. 8, L	ine 28.						
BHF Page 2 - Adjusted the Part II-Program discharges to agree	e with the IPCR							
BHF Page 3 - Adjusted the Total Costs to agree with W/S C, P								
BHF Page 3 - Implants costs/charges are included in the Medic		care report						
BHF Page 3 - Partial Hospital and PT report costs; adjusted ou BHF Page 3 - Reclassified \$2,051 of Drug I/P charges to drugs								
BHF Page 3 - I/P Charges agree with the IPCR	man dang dappind							
BHF Page 4 - Adjusted the Routine costs to agree with W/S C,								
BHF Page 4 - Routine Costs on line 1a allocated between A&P and Psych; see attached spreadsheet								
BHF Page 4 - Included observation days in A&P, line 1b	- IDOD							
BHF Page 6b - Adjusted out the professional fees as none on the IPCR BHF Page 7 - Routine charges agree with the IPCR								
Dill Tage 7 - Noutille charges agree with the IT CIX								
								